PATIENT INFORMATION FORM

PATIENT DATA

Last Name: ___________________________ First Name: ________________________________Middle Initial:_______

Date of Birth: ________________________ Social Security: ______________________ Gender: □ Female □ Male

ADDRESS

Address: ____

City: ____State: ________________________ Zip: _____________

PHONE

Home: ___________________________ Work: _________________________ Mobile: __________________________

EMAIL

Email: ____

RESPONSIBLE PERSON • PATIENTS 18 & UNDER ONLY

Last Name: _______________________________ First Name: _____________________________Middle Initial:______

Address: ____

City: ____State: ________________________ Zip: _______________

EMERGENCY CONTACT

Last Name: __________________________ First Name: ______________________ Home Ph:____________________

REFERRAL
How did you hear about us? ____

Please leave blank to be filled out by office staff

	CPT CODES
Insurance:______________________________ **Copay**: ____________ **Deductible:**___________ **Follow Up:** _____________ **RF** ☐	

PATIENT HEALTH QUESTIONNAIRE

All information collected in this questionnaire is strictly confidential and will become part of your medical record. Please bring this completed form with you to your consultation

PATIENT DATA

Last Name:_______________________________ First Name:____________________________ MI: _________

Date of Birth:_______________________ Occupation / Employer:_______________________________________

Primary Care Physician: _____________________________ **Referring Physician**: ______________________

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Race:
☐ White
☐ Black or African American
☐ American Indian or Alaska
☐ Native Hawaiian or Pacific Islander
☐ Asian
☐ Other

What are you seeing the dermatologist for today? ____

PAST MEDICAL HISTORY

Have you had any of the following conditions?

□ Anxiety
□ Arthritis
□ Artificial Joints
□ Asthma
□ Atrial Fibrillation (Irregular Heartbeat)
□ BPH
□ Bone Marrow Transplantation
□ Breast Cancer
□ Colon Cancer
□ COPD
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ End Stage Renal Disease
□ GERD
□ Hearing Loss
□ Hepatitis
□ Hypertension
□ HIV/AIDS
□ Hypercholesterolemia
□ Hyperthyroidism
□ Hypothyroidism
□ Leukemia
□ Lung Cancer
□ Lymphoma
□ Prostate Cancer
□ Radiation Treatment
□ Seizures
□ Stroke

Other:____

PAST SURGERIES

Have you had any previous surgeries? If so, what and when? _______________________________________

SKIN DISEASE HISTORY

Have you had any of the following conditions?

□ Acne
□ Actinic Keratoses
□ Asthma
□ Basal Cell Skin Cancer
□ Blistering Sunburns Melanoma
□ Dry Skin
□ Eczema
□ Flaking or Itchy Scalp
□ Hay Fever/Allergies
□ Poison Ivy
□ Precancerous Moles
□ Psoriasis
□ Squamous Cell Skin Cancer

Other: ____

PATIENT HEALTH QUESTIONNAIRE *(continued)*

Do you wear sunscreen? □ Yes □ No If yes what SPF: __________________

Do you tan in a tanning salon? □Yes □ No

FAMILY HISTORY

Do you have a family history of melanoma? ☐ Yes ☐ No If yes, which relative/s? ______________

SURGICAL HISTORY

Have you ever had difficulty stopping bleeding? ☐Yes ☐ No

Do you require antibiotics prior to a surgical procedure? ☐ Yes ☐ No

Have you had an artificial joint replacement? ☐ Yes ☐ No If yes, when and where? _____________

Do you have an artificial heart valve? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Do you have a defibrillator? ☐ Yes ☐ No

PREGNANCY

Are you pregnant or currently trying to get pregnant? ☐ Yes ☐ No

MEDICATIONS

Are you currently on prescription medication? ☐ Yes ☐ No If yes, please list:

____

Do you take over-the-counter drugs, vitamins, supplements or use inhalers? ☐ Yes ☐ No

If yes, please list: ____

____

PREFERRED PHARMACY INFORMATION

Pharmacy Name: _____________________________ Phone: ______________________________

Address: ____

ALLERGIES

Do you have any allergies? ☐Yes ☐ No If yes, what? _________________________

SOCIAL HISTORY

Please check all that apply.

☐ Currently smokes ☐Drug use

☐ Has smoked in the past ☐Alcohol use

Other: ____

COSMETIC QUESTIONNAIRE

LET US KNOW IF YOU'RE INTERESTED …

- ☐ Acne or Acne Scarring
- ☐ Age Spots
- ☐ Botox/Dysport/Xeomin
- ☐ Body Sculpting/Coolsculpting/ Zeltiq (Freeze the Fat)
- ☐ Fillers
- ☐ Chemical Peels
- ☐ Excessive Sweating
- ☐ Ulthera/Thermage (non surgical face & brow lift)
- ☐ Loss of Collagen
- ☐ Laser Resurfacing/Fraxel
- ☐ Laser Hair Removal
- ☐ Rosacea or Broken Capillaries
- ☐ Spider Vein Treatments
- ☐ Sun Damage & Prevention
- ☐ Hyperpigmentation/Melasma

WHAT WOULD YOU LIKE TO IMPROVE?

____

____

____

____

TELL US ABOUT YOUR SKINCARE REGIMEN…

AM Routine

Cleanser: ____

Prescription Products:____

Facial Day Cream / Serum: ____

Sunscreen: ____

Other: ____

PM Routine

Cleanser: ____

Prescription Products: ____

Daniel Behroozan, MD, FAAD
www.dermsurgery.net
T: 310.392.1111 F: 310. 392.1101
2221 Lincoln Blvd, Suite 100 Santa Monica, CA 90405
9301 Wilshire Blvd, Suite 406 Beverly Hills, CA 90210

Facial Night Cream / Serum: ____

Other: ____