Pacific Dermatology & Cosmetic Laser Center

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Patient Personal Information

Patient (Dr. Mr. Mrs. Ms. Miss) Last_____ First_____ Middle Initial_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Age_____ ○ Male ○ Female

Home Phone_____ Cell Phone_____

Marital Status ○ Single ○ Married ○ Other_____

Please provide your e-mail address. This is important for specials and promotions we may be offering to our email list.

E-mail_____

Preferred pharmacy_____ Pharmacy City/Zip Code _____

How did you hear about us?

○ Friend_____ ○ Physician_____ ○ Media_____

○ Family member_____ ○ Website ○ Other_____

Ethnicity: ○ American Indian or Alaska Native ○ Asian ○ Black or African American

○ White ○ Hispanic/Latino ○ Declined to specify ○ Other_____

Patient Medical Information

Reason for today's visit: _____

How long has this been a problem? _____Days _____Weeks _____Months _____Years

Where is this located? _____

Does this cause any of the following symptoms? (circle all that apply)

Burning Itching Stinging Bleeding Scaling Irritation Pain Changing Colors Changing Shape Growing Other:

What treatments have made this better? _____

What treatments have made this worse? _____

Do you have a history of Skin Cancer? ○ Yes ○ No

If yes type? ○ Basal Cell Carcinoma ○ Squamous Cell Carcinoma ○ Melanoma

Do you have a family history of Skin Cancer? ○ Yes ○ No

If yes type? ○ Basal Cell Carcinoma ○ Squamous Cell Carcinoma ○ Melanoma

Do you have any allergies to medications? ○ **Yes** ○ **No**

If yes, please list:_____

Do you have any allergies to the following: ○ Yes ○ No

If yes, please circle: Latex Tape Adhesives Bandages Lidocaine Polysporin Neosporin Bacitracin

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Patient Medical Information, Continued

Patient Name_____

Patient Medical History

Please check below if you have ever had or currently have any of the following (check all that apply)

- ○ Allergies to medications
- ○ Allergy to local anesthesia
- ○ Heart disease or high blood pressure
- ○ Pacemaker
- ○ Antibiotics before dental procedures
- ○ Lung disease or emphysema
- ○ Asthma or hay fever
- ○ Sinus problems or allergies
- ○ Seizures or headaches
- ○ Fainting spells
- ○ Emotional or psychiatric problems
- ○ Digestive problems or ulcers
- ○ Medical anti-aging treatment injections
- ○ Liver disease or hepatitis
- ○ Arthritis
- ○ Joint replacements
- ○ Kidney problems
- ○ Problems with eyesight
- ○ Anemia or bleeding problems
- ○ Diabetes (___Type 1 _____Type 2)
- ○ Thyroid disease
- ○ Diagnosis of HIV or AIDS
- ○ Chronic skin conditions
- ○ Eczema or atopic dermatitis
- ○ Skin cancer
- ○ Vitiligo
- ○ Abnormal moles
- ○ Bleed easily
- ○ History of keloids or thick scars
- ○ X-ray or Grenz ray treatments

The following questions are for female patients only.

Do you have polycystic ovaries?	○ Yes	○ No	Do you take oral contraceptives (OCCs)?	○ Yes	○ No
Do you have menstrual periods?	○ Yes	○ No	Do OCCs make your skin uneven?	○ Yes	○ No
If so, are your periods regular?	○ Yes	○ No	Are you on hormone treatments?	○ Yes	○ No
Are you pregnant?	○ Yes	○ No	Do you have new facial hair growth?	○ Yes	○ No
Are you planning a pregnancy?	○ Yes	○ No	Do you have recurring/frequent yeast infections?	○ Yes	○ No

Family History

Has anyone in your family ever had any of the following? (please check all that apply)

- ○ Diabetes
- ○ Systemic lupus erythematosus
- ○ Scleroderma
- ○ Psoriasis
- ○ Vitiligo
- ○ Asthma, eczema, or hives
- ○ Melanoma
- ○ Nonmelanoma skin cancer

Patient Social History

Use of Alcohol	○ Never	○ Occasional	○ Moderate	○ Previous/quit_____
Use of Tobacco	○ Never	○ Occasional	○ Moderate	○ Previous/quit_____
Use of Recreational Drugs	○ Never	○ Occasional	○ Moderate	○ Previous/quit_____

Please list all medications you are taking, including vitamins, laxatives, pain relievers, and herbal remedies.

_____

Please list any surgical procedures you have had.

_____

Please list any other medical conditions or problems you may have that were not addressed above.

_____