Pacific Dermatology & Cosmetic Laser Center

Dr Douglas M Keel
Office 858.535.1400
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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.

_____

Pacific DERMATOLOGY & COSMETIC LASER CENTER

DR DOUGLAS M KEEL
OFFICE 858.535.1400
FAX 858.535.1900

HIPAA Consent

I hereby give my consent for Pacific Dermatology & Cosmetic Laser Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Pacific Dermatology & Cosmetic Laser Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pacific Dermatology & Cosmetic Laser Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pacific Dermatology & Cosmetic Laser Center's Privacy Officer, Heather Kenney at 8899 University Center Lane STE 150 San Diego, CA 92122.

With this consent, Pacific Dermatology & Cosmetic Laser Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Pacific Dermatology & Cosmetic Laser Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Pacific Dermatology & Cosmetic Laser Center may e-mail or text me, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Pacific Dermatology & Cosmetic Laser Center restrict how it discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions.

By signing this form, I am consenting to Pacific Dermatology & Cosmetic Laser Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Pacific Dermatology & Cosmetic Laser Center may decline to provide treatment to me.

X _____ _____ _____

Signature of Patient (or guardian if patient is under 18) | **Relationship to Patient (if signed by guardian)** | **Date**

X _____

Please print the name of the patient