____

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: ____

Your email will be used for internal communications from our office only. We will NEVER sell your personal information

What is your preferred contact method? Please circle one Phone Email Letter

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

Insurance: ______________________________

Copay: ____________ Deductible: ___________

Follow Up: _____________ RF ☐

CPT CODES

Daniel Behroozan, MD, FAAD
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2221 Lincoln Blvd, Suite 100 Santa Monica, CA 90405
9090 Burton Way, Beverly Hills, CA 90211

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

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: ____

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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? _______________

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

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

Do you have a family history of Alopecia? ☐ 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

Prescriptions will be sent electronically to your pharmacy

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: ____

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IF ANY OF THE FOLLOWING QUESTIONS CONCERN YOU PLEASE CHECK THE APPROPRIATE BOX

Do you have unwanted wrinkles?	☐ Yes	☐ No
Do you have increased skin laxity?	☐ Yes	☐ No
Are you interested in using topical Anti-Aging products?	☐ Yes	☐ No
Do you have acne scars or Brown Spots?	☐ Yes	☐ No
Do you suffer from excessive sweating?	☐ Yes	☐ No
Do you have stubborn fat that diet and exercise don't seem to get rid of?	☐ Yes	☐ No
Are you interested in learning about injections of PRP to stimulate hair growth?	☐ Yes	☐ No
Would you like to meet with our aesthetician for a complimentary skin care evaluation?	☐ Yes	☐ No

At the Dermatology Institute of Southern California, we believe in the addition of a skin care regimen ***Backed by Science*** *to compliment your medical care in our office.*

If you would like to learn more about evidence-based skin care products, please check here ☐

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