DERMATOLOGY INSTITUTE
OF SOUTHERN CALIFORNIA

# 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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Follow us on @drdanbehroozan

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2221 Lincoln Blvd, Suite 100 Santa Monica, CA 90405
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# 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:** **Race:**

☐ Hispanic or Latino ☐ White ☐ Black or African American

☐ Not Hispanic or Latino ☐ American Indian or Alaska ☐ Native Hawaiian or Pacific Islander

☐ Unknown ☐ 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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