THE CENTER FOR DERMATOLOGY CARE
267 W. HILLCREST DRIVE
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PHONE (805) 497-1694 ♦ FAX (805) 373-7493

PATIENT INFORMATION	Patient Name: ______________________
	Date of Birth: ______________________
	Today's Date: ______________________

Please take a few moments to fill out the following information. Answer all of the questions below to the best of your knowledge.

I. Personal Information

Occupation:______________________

Emergency Contact (name/phone number): ______________________

Who we may thank for referring you: ______________________

Address: ______________________

Telephone: ______________________ Email address: ______________________

The doctors specialize in a number of cosmetic procedures. Are you also interested in scheduling a consultation for any of the following:

Laser treatment of wrinkles or blood vessels	______Yes	______No
Hair Transplantation	______Yes	______No
Treatment of deep wrinkles with Soft-Tissue Fillers	______Yes	______No
Liposuction	______Yes	______No
Botox treatment of frown lines or crow's feet	______Yes	______No
Sclerotherapy of spider veins	______Yes	______No
CoolSculpt (Freezes localized fat areas)	______Yes	______No
Laser Hair Removal	______Yes	______No

II. Health Information

A. *General health questions*

1. **Are you prone to or do you have any of the following conditions?**

• Difficulty with healing of wounds	______Yes	______No
• Bleeding tendency	______Yes	______No
• Diabetes	______Yes	______No
If yes, treatment: ______________________		
• Heart Problems	______Yes	______No
If yes, treatment: ______________________		
• Hypertension	______Yes	______No
If yes, treatment: ______________________		
• Emotional Disorders	______Yes	______No
• Rheumatic Fever or history of heart-valve or joint replacement	______Yes	______No
• Glaucoma	______Yes	______No

- Overgrown scars of keloids ______Yes ______No
- Allergies ______Yes ______No
  If yes, what types: ________________________________
- HIV or other immunodeficiency ______Yes ______No
- Hepatitis or other liver or kidney disease ______Yes ______No

2. **What medications are you presently taking?** (Please include aspirin, cold medicines, digestive aids, etc____

____

Do you require antibiotics before dental procedures? ______Yes ______No

3. **Have you been hospitalized in the past?** ______Yes ______No
   If yes, when: ____
   reason: ____

4. **Other medical problems:**____

   ____

5. **What is your original hair color?**
   ___White ___ Blonde ___ Brown ___ Red ___ Black ___Other: ______________

6. **What is your eye color?**
   ___Blue ___Green ___Brown ___Gray ___Hazel ___Other:____________

7. **What is your ethnic background (e.g. French, English, etc)?**
   Mother: ________________________________ Father: ________________________________

8. **What is your skin color without tanning?**
   ___White ___Black ___Brown ___Yellow ___Other: ______________________

9. **What is your complexion like?**
   ___Fair ___Medium ___Dark ___Other: ____________________________________

B. *Sun Exposure History*

1. **Place of birth:** ____

2. **How long have you lived in California?** ______________________________

3. **Have you served in the Armed Forces?** ______Yes ______No
   If yes, where were you stationed? ____________________________________

4. **Did you or do you travel to tropical climates?** ______Yes ______No
   If yes, how often?______________________ and where?__________________________

5. **Do you engage in outdoor activities for work or recreation?**
   ___Yes ______No If yes, please describe: ____________________________________

6. **When do you do most of your outdoor activities?**

___Before 10 AM ___Between 10 AM and 2 PM ___After 2 PM

7. **What is the usual amount of time spent outside in a single day (either for work for recreation)?** ___0-2 hours/day ___2-4 hours/day ___4-6 hours/day ___6-8 hours/day

8. **When outdoors do you wear any of the following items to protect yourself from the sun?** ______a hat ______a long-sleeved shirt ______long pants

9. **Do you regularly use a sunscreen?** ______Yes ______No

   If yes, what is the SPF and the brand name of the sunscreen that you usually use? _____

10. **When do you apply sunscreen?**

    ___Only when I am planning on being outdoors for work or recreational activity

    ___Daily during the sunny days

    ___I do not use sunscreen

11. **When in the sun, are you most likely to (check one of the following):**

    ___Always burn/Never tan ___Usually burn/Rarely tan

    ___Sometimes burn/Sometimes tan ___Rarely burn/Usually tan

    ___Never burn/Always tan ___Other: ___________________________________

C. *Smoking History*

1. **Do you or have you ever smoked?** ______Yes ______No

   If yes, please indicate:

   • Nature of smoking (cigarettes, cigars, pipes):____

   • How many a day? ____________________ • For how many years?_________________

   • If you are a former smoker, how long ago did you stop?_________________________________

D. *Skin Cancer History*

1. **Have you had any type of skin cancer (basal cell carcinoma, squamous cell carcinoma, melanoma, other) in the past?** ______Yes ______No

   If yes, please indicate:

   • Diagnosis, if known: ____

   • Age at initial diagnosis: ______________________ • How many: ___________________

   • Location(s): ____

   • Treating physician: ____

   • Type of treatment: ____

2. **Have you had any pre-cancer (actinic keratosis) in the past?** ______Yes ______No

   If yes, please indicate:

   • Age at initial diagnosis: ________________ • Approximate number: _________________

- Location(s): ______________________________
- Treating physician: ______________________________
- Type of treatment: ______________________________

3. **Do you have any irregular-looking moles?** ______Yes ______No

   If yes, please indicate:
   - Diagnosis, if known: ______________________________
   - Age at initial diagnosis: ____________ • How many: ____________
   - Location(s): ______________________________
   - Treating physician: ______________________________
   - Type of treatment: ______________________________

4. **Does anyone in your family have skin cancer?** ______Yes ______No

   If yes, please indicate:
   - Diagnosis, if known: ______________________________
   - Relationship: ____________ • Number of cancers: ____________
   - Location(s): ______________________________
   - Was it fatal? ______Yes ______No

E. *Other Cancer History*

1. **Do you have or have you had cancer other than skin cancer?** ______Yes ______No

   If yes, please indicate:
   - Diagnosis, if known: ______________________________
   - Location: ______________________________
   - Type of treatment: ______________________________

2. **Does anyone in your family have cancer other than skin cancer?** ____Yes ______No

   If yes, please indicate:
   - Diagnosis, if known: ______________________________
   - Location: ______________________________
   - Type of treatment: ______________________________
   - Was it fatal? ______Yes ______No

F. *Carcinogen Exposure History*

1. **Exposure to arsenic or carcinogens (at home or at work)**

   ___no ___yes ___don’t know

2. **Radiation Exposure other than routine chest and dental x-rays**

   ___no ___yes, type:______________________________