The Center For Dermatology Care 267 W. Hillcrest Drive Thousand Oaks, CA 91360 Phone: (805) 497-1694	
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: ____

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, tattoos or blood vessels	___**YES**	___**NO**
Hair Transplantation	___**YES**	___**NO**
Treatment of deep wrinkles with Collagen, fat or SoftForm	___**YES**	___**NO**
Liposuction (Tumescent)	___**YES**	___**NO**
Botox treatment of frown lines or crow's feet	___**YES**	___**NO**
Sclerotherapy of spider veins	___**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 or 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 really 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 <u>one</u> 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: ____________________ How many: __________
   - 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(s): ______________________________
- 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(s): ______________________________
- 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: ____________

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G. *Comments*

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