KARIMIPOUR DERMATOLOGY AND AESTHETIC SURGERY
New Patient Health History Form

Today's date: _____ NAME: _____
Your age: _____ Date of Birth: _____
Occupation: _____
Marital Status: _____ Sex: M / F Visit No. _____
Race and Ethnic Group: _____
Home phone #: _____
Work or other phone #:_____

Dr. who sent you here: _____Tel: _____City: _____

Your **Family** Dr.:_____ Tel: _____ City: _____

Your **Heart** Dr.: _____ Tel: _____ City: _____

Other Dr.:_____ Tel: _____ City: _____

Pharmacy: _____ Tel: _____ City: _____

Have you had a skin cancer treated by Mohs surgery before? NO / YES If yes, when? _____

Regarding the spot(s) that you were sent to us for:

1st spot: Where is it on your body? _____
How long have you had this spot? _____
Has it been (circle) Itching? Painful? Bleeding? Growing? Crusting? Other: _____
Not counting the biopsy, has it been treated before? NO / YES if yes, please explain how: _____
_____

2nd spot: Where is it on your body? _____
How long have you had this spot? _____
Has it been (circle) Itching? Painful? Bleeding? Growing? Crusting? Other: _____
Not counting the biopsy, has it been treated before? NO / YES if yes, please explain how: _____
_____

Please list all medications including prescriptions, over the counter (vitamins/aspirin/etc), supplements-herbs you take regularly.

MEDICATION/DOSE	FREQUENCY	MEDICATION/DOSE	FREQUENCY	MEDICATION/DOSE	FREQUENCY

Are you allergic to any medications? (Mark "X")

_____ NO, I have no known drug allergies.
_____ YES, I am allergic to the following medicines. (Please, explain below)

1._____Reaction_____
2._____Reaction_____
3._____Reaction_____

- Do you use sunscreen on a daily basis? NO/YES If YES, what SPF? _____
- Do you use a tanning bed? NO/YES
- Have you had 5 or more sunburns in your lifetime? NO / YES
- Have you had radiation treatment to your skin? NO / YES
  If yes, where on your body and for what? _____
- Do you smoke? NO / YES
- Consume any alcohol? If yes, please specify. _____

Please check either N for no or Y for yes in each row:

IMPORTANT MEDICAL HISTORY	**N**	**Y**	**CONTINUED**	**N**	**Y**
History of Heart attack WHEN? _____			HIV / AIDS		
Angina/Chest Pain WHEN? _____			Hepatitis / liver problems		
Arrhythmia (irregular heartbeat)			Diabetes		
Pacemaker/Automatic Implanted Cardiac Device			High blood pressure		
Defibrillator			Auto immune disease(Lupus, other)		
Murmur			Hypo or Hyperthyroidism (circle)		
Artificial heart valve			Bleeding problems (such as clotting etc.)		
Require antibiotics before procedures, Please explain			Arthritis		
			High Cholesterol		
Other heart problems, Please explain			Hearing Loss		
Cancer (other) / Type:			Vision Loss?		
Organ Transplant / Which organ and date:			Gastrointestinal problems		
Seizures. When? _____			Skin disorders?		
Lung problems, Asthma, Emphysema, Sleep Apnea? (Please Circle one) or explain:_____			Artificial joints/pins. Where and When?		
Do you need supplemental O2 or CPAP?			Psychiatric disorder		
Stroke/Mini-stroke (TIA) When? _____ (Please circle one)			Pregnant or breast feeding Due date:		

If you have had a major illness or major surgery in the past 5 years, please explain: **Month/Day /Year**

_____ _____

_____ _____

_____ _____

Do you have a <u>family</u> history of Cancer? YES___ NO___

If <u>YES</u>, which family member and which type of cancer? Please only list first degree relatives (Parents, Siblings, Grandparents, Children, Grandchildren, Aunt, Uncle, Niece, Nephew).

Family member	**Type of cancer**