heidi goodarzi md
949 679 1990
www.gooddderm.com

Patient Name: ______________________ Date of Birth: ____/____/______
Today's Date: ____/____/______ Appointment Time: ___________

New Patient Demographics Form

Name: ____
(Please Print First, M, Last)

Date of Birth: _________________________

Sex: ☐ Female ☐ Male **Marital Status:** ________________ **SSN:** _____________________

Home Address:____

Email: _____________________________________ Can we contact you at this email address? ☐Yes ☐No

Preferred Phone Number: _____________________**Alternate Phone Number:** ______________________

Responsible Party (if different from patient) Name: ____
Relationship to patient: _______________ Phone:___ ________________
Address: ____

Emergency Contact: Name: _____________________________ Phone: ____________________________
Relationship to patient: ______________________________

How did you hear about us? (Please check all that applies) ☐ Your Insurance ☐ Another Physician
☐ Friends or Family: _________________ ☐ Website ____________ ☐ Other :

Preferred Language: _________________________

Race: ☐White ☐Black/African American ☐American Indian or Native Alaskan
☐Asian ☐Native Hawaiian/Pacific Islander ☐ People of Two or More Races

Ethnicity: ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐ Unspecified

Pharmacy: Name:____
Address or cross street: ____

Primary Care Physician: ____
phone: ___________________ Fax: ________________________

Referring Physician: ____
phone: ___________________ Fax: _________________________

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New Patient Clinical Intake Form

Past Medical History: (please mark & circle all that apply)

- ☐ Arthritis, Lupus, Autoimmune Disease
- ☐ Hepatitis B, Hepatitis C, HIV, AIDS
- ☐ Blood transfusion, Bone Marrow or Organ Transplant
- ☐ Anxiety, Depression, Eating Disorder, Psychological problems
- ☐ Asthma, Tuberculosis, COPD, Emphysema, Chest Disease
- ☐ Acid Reflux, (GERD), Stomach Ulcers
- ☐ Faint Spells, Seizures, Stroke, Neurological Disease
- ☐ High or Low Blood pressure, High Cholesterol
- ☐ Diabetes, Thyroid disease
- ☐ Liver Disease, Jaundice, Cirrhosis
- ☐ Artificial Joints
- ☐ Drug Abuse, Alcohol Abuse
- ☐ Hearing Loss
- ☐ Kidney Disease, Prostatic Disease
- ☐ Migraines, Headaches, Chronic Pain
- ☐ Anemia, Blood/Bleeding Disease
- ☐ Heart Disease, Pacemaker, Valve Replacement, Atrial Fibrillation, Coronary Artery Disease
- ☐ Breast Cancer, Lung Cancer, Colon Cancer, Prostate Cancer, Leukemia, Lymphoma
- ☐ Radiation Treatment ☐ Other ___________________________ ☐ None

Have you had any surgeries in the past? (Please indicate dates): ____________________________________

____

Skin Disease History: (please circle all that apply)

- ☐ Acne, Acne Scarring ☐ Blistering Sunburns ☐ Abnormal Moles ☐ Melanoma Skin Cancer
- ☐ Flaking or Itchy Scalp ☐ Dry Skin, Eczema ☐ Psoriasis ☐ Asthma/Hay fever/Allergies
- ☐ Cold sores/Fever blisters/Oral Herpes/Genital Herpes ☐ Shingles
- ☐ Actinic Keratoses/Pre-cancerous lesions ☐ Basal Cell Carcinoma or Squamous Cell Carcinoma
- ☐ Sexually transmitted disease/Veneral disease ☐ Other Skin Disease:____________________

Do you wear Sunscreen? ☐ Yes (Brand? ____________________) ☐ No

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes (which relative(s)? _________________________ ☐ No

When was your last full skin exam? ____

Medications: (Please enter all current medications): ____

____

Allergies: (Please enter all allergies and the type of reaction you had): ___________________________________

____

Social History:

Smoking: ☐ Never smoked ☐ Quit: former smoker ☐ Smokes everyday ☐ Smokes some days

Drinking : ☐ No alcohol ☐ Less than 1 drink a day ☐ 1-2 drinks a day ☐ 3 or more drinks a day

Domestic violence screening: ☐ Patient feels safe at home ☐ Patient feels unsafe at home

Current Sexual practice: ☐ Not sexually active ☐ Sexually active with one partner ☐ Same-sex partner (homosexual) ☐ Sexually active with more than one partner

Occupation: _________________________________ Employer: ____

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Main reason for Today's visit:____________________________________ **Location?** _________________

Qualities? ☐Itching ☐flaking ☐Pain ☐Burning/Blistering ☐Enlarging/Changing ☐Darkening ☐Other:____

Severity of your condition (severity)**?** ☐ Mild ☐ Moderates ☐ Severe

Duration of your condition? ____days ____ months ____years

Anything that makes your condition better or worse (modifying factors)**?**________________________________

Have you used any prescription medication for your condition?________________________________

Is there another skin condition or treatment you would like to discuss? ___________________________

Review of Systems: TODAY, are you experiencing any of the following symptoms?

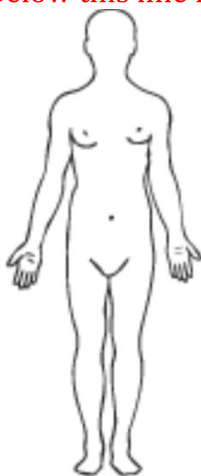
☐ Problems with healing or scarring (hypertrophic or keloid) ☐ Problems with bleeding
☐ Fevers or Chills ☐ Unintentional Weight loss ☐ Immunosuppression
☐ Joint Aches ☐ Headaches ☐ Shortness of Breath
☐ Chest Pain ☐ Abdominal Pain ☐ None

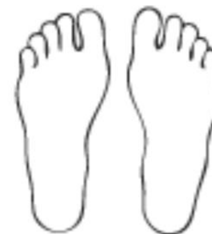
! SAFETY ! To help us provide safe treatments, please mark all that apply to you today:

- Pregnancy or planning a pregnancy ☐Yes ☐No
- History of MRSA/resistant staphylococcus infection ☐Yes ☐No
- History of or exposure to HIV infection ☐Yes ☐No
- History of or exposure to Hepatitis B or Hepatitis C ☐Yes ☐No

- Allergy to any of the following? ☐Adhesives ☐Lidocaine ☐Topical Antibiotics ☐Bees
- Do you get rapid heart beat with numbing injections (epinephrine) ☐Yes ☐No
- Do you have a Defibrillator, Pacemaker, Artificial heart valve, or Artificial joints placement? ☐Yes ☐No
- Are you required to take antibiotic premedication prior to surgical procedures? ☐Yes ☐No
- Are you on any blood thinners? ____ ☐Yes ☐No

Below this line is for office use ONLY





Benign Nevi: ☐ Observation AK: ☐ LN2 Xerosis/Skin Education Acne AM_____________
Neo. ☐Shave bx ☐Punch Bx SK: ☐ LN2 Lentigenes/Angiomas Acne PM______________
Dermatitis________________________ Products: __________________________________ F/U: ________