heidi goodarzi md
949 679 1990
www.gooddern.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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Patient Name: ______________________ Date of Birth: ____/____/______
Today's Date: ____/____/______ Appointment Time: ___________

New Pediatric Patient Clinical Intake Form

Main reason for Today's visit:____

Qualities of your condition? ☐ Itching/ flaking ☐ Pain/tenderness ☐ Burning /Blistering
☐ Enlarging/ Changing/Darkening ☐ No symptoms ☐ Other: ___________________

Severity of your condition? ☐ Mild ☐ Moderates ☐ Severe

Duration of your condition? ____days ____ months ____years

Anything that makes your condition better or worse?____

Have you used any prescription medication for your condition?___________________________________

Do you have any of the following Symptoms? ☐Fevers/Chills ☐Cough/Soar Throat ☐Recent illness

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

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
☐ Heart Disease, Pacemaker, Valve Replacement, Atrial Fibrillation, Coronary Artery Disease
☐ Breast Cancer, Lung Cancer, Colon Cancer, Prostate Cancer, Leukemia, Lymphoma
☐ Radiation Treatment
☐ 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
☐ Other ___________________________

Pediatric History:

Gestational age at birth (in weeks)? ________________________

Maternal or Neonatal complications?________________________

Meeting Developmental Milestones? ☐Yes ☐No

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

____

Do you have any history of skin disease?____

Do you wear Sunscreen? ☐Yes ☐No Which Brand? ____________________

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

Do you have a family history of Melanoma? (please pay attention that melanoma is a different type of skin cancer than Basal Cell Carcinoma, Squamous Cell Carcinoma and others)

☐Yes (which relative(s)? ________________ ☐No

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Medications: (Please enter all current medications): ____

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

____

Social History:
- ☐ Who does the child live with? ____
- ☐ Other caregivers? ____
- ☐ Siblings/Their ages?____
- ☐ Do you smoke?____
- ☐ Are you sexually active?____

Review of Systems: TODAY, are you experiencing any of the following symptoms? ☐ Rash
☐ Problems with healing, scarring (hypertrophic or keloid) or bleeding
☐ Fevers/Chills/Night sweats ☐ Unintentional Weight loss
☐ Immunosuppression ☐ Joint Aches/Muscle Weakness ☐ Headaches ☐ Shortness of Breath
☐ Chest Pain ☐ Abdominal Pain

! 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? Adhesive, Lidocaine, Bees, Topical Antibiotics? ☐Yes(please circle) ☐No
- Do you get rapid heart beat with epinephrine? ☐Yes ☐No
- Do you have a Defibrillator, Pacemaker, or Artificial heart valve? ☐Yes ☐No
- Artificial joints placement within past two years ☐Yes ☐No
- Premedication prior to procedures ☐Yes ☐No
- Are you on any blood thinners? ☐Yes ☐No
- Have you taken any of the following in the last 2 weeks? ☐Yes(please circle) ☐No

Aspirin (or aspirin containing medications), Vitamin E, Anti-inflammatories or muscle relaxants, Ibuprofen/Motrin/Advil/Nuprin

Below this line is for office use ONLY