

**URBAN DERMATOLOGY PLLC  
ELIZABETH I. GOLDBERG, MD**

**PATIENT INFORMATION FORM**

Reason For Visit: \_\_\_\_\_ Date: \_\_\_\_\_

General Skin Exam       Botox       Laser Treatment  
 Chemical Peel       Restylane/Other Fillers       Other Medical

Patient Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Occupation: \_\_\_\_\_

Originally Referred By: \_\_\_\_\_

**INSURANCE INFORMATION**

Name of Company: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PATIENT/FAMILY HEALTH HISTORY**

Are you under the care of a physician?  For what? \_\_\_\_\_

Have you or any blood relatives of your family had any of the following conditions or treatments?

Heart Disease?	Yes No	Stomach Ulcers?	Yes No
High/Low Blood Pressure?	Yes No	Hives/rashes?	Yes No
Shortness of breath/Fainting?	Yes No	Skin Cancer?	Yes No
Palpitations/irregular heart beat?	Yes No	Alcohol or drug abuse?	Yes No
Mitral Valve prolapse/valve disease?	Yes No	Diabetes?	Yes No
Hepatitis/liver disease?	Yes No	Thyroid disease?	Yes No
Asthma/TB/cough/pulmonary disease?	Yes No	X-ray/radiation treatment?	Yes No
Kidney Failure or problem?	Yes No	Bad reaction to anesthesia?	Yes No
Migraines/headaches/chronic pain?	Yes No	Poor scar formation/healing?	Yes No
Lupus/arthritis/autoimmune disease?	Yes No	Venereal Disease?	Yes No
Psychological/emotional disorder?	Yes No	Anaphylaxis?	Yes No
Phlebitis/varicose veins/bloodclots?	Yes No	Recent Weight gain or loss?	Yes No
Stroke/seizure/neurologic disorder	Yes No	Do you have a pacemaker?	Yes No
Herpes/fever blister/shingles?	Yes No	HIV/AIDS?	Yes No
Anemia/blood disorder?	Yes No	Other: _____	
Excessive or abnormal bleeding?	Yes No	_____	
Blood transfusion?	Yes No		

If yes, who? \_\_\_\_\_

**SURGICAL HISTORY**

Have you had any past surgeries? Please list.

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**SOCIAL HISTORY**

Do you use alcohol? \_\_\_\_\_ How often? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Packs per day. \_\_\_\_\_ For how long? \_\_\_\_\_

**MEDICINES**

Do you take any medicines? Please list.

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Have you taken any of the following in the last 6 months?

Accutane	Yes No	Vitamin E	Yes No
Predisone	Yes No	Ibuprofen	Yes No
Birth-control pills	Yes No	Anti-inflammatories	Yes No
Anti-coagulants or blood thinners	Yes No	Herbs/supplements	Yes No
Aspirin	Yes No		

**ALLERGIES**

Are you allergic to any medicines?

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Have you had any adverse reactions to:

lidocaine/novocaine/anesthetic?	Yes No
Iodine/betadine/chlorhexadine/other skin wash?	Yes No
Adhesive tape?	Yes No
Latex Rubber?	Yes No

**PREGNANCY**

Are you pregnant?	Yes No
Are you breast feeding?	Yes No
Are you currently using birth control?	Yes No

I certify that the above is true I and correct. I am not withholding any medical history and I understand that doing such could result in serious harm to myself or those involved in my medical care.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_