

**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.

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.

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?

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 _____