Pasadena Dermatology

***** The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Name:_____ **D.O.B.**_____/_____/_____ **Date:** ___/___/____

Telephone #: Home: (_____)_____ Cellular: (_____)_____

Occupation: _____ **Allergies:**_____

Health problems:

_____

_____

_____

Medications/Supplements:_____

_____

_____

Social History: *Tobacco use*: No/Yes *Alcohol*: No/Yes *Hepatitis*: No/Yes

Family Health Problems:

_____

_____

Please check if you had the following problems, past or present:

	NO	**YES, Please Explain**
Heart Disease		
High Blood Pressure		
Stroke		
Fainting Spells		
Infectious Disease		

----Continued on Next Page----

	NO	YES, Please Explain
Blood Disorders		
Organ Transplant		
Visual Disorders		
Lung Disease		
Liver Disease		
Kidney Disease		
Thyroid Disease		
Adrenal Gland Disease		
Cancer		
Diabetes		
Latex Allergy		
Back or Neck Problems		
Blood Clots		
Pacemaker		
Are you currently Pregnant?		

Emergency Contact Information:
(_____)_____

Relationship:_____ **Permission to Contact in an Emergency**: Yes/No

Patient's Signature:

_____

The above is true and correct to the best of my belief