ALLIANCE DERMATOLOGY MEDICAL QUESTIONNAIRE – PHONE (602) 971-0268

PT NAME:_____**DOB:**_____

PAST MEDICAL HISTORY -PLEASE CIRCLE ALL THAT APPLY

- ANXIETY
- ARTHRITIS
- ASTHMA
- ATRIAL FIBRILLATION
- BONE MARROW
- TRANSPLANTATION
- BREAST CANCER
- COLON CANCER
- COPD
- CORONARY ARTERY DISEASE
- DEPRESSION
- DIABETES
- END STAGE RENAL DISEASE
- GERD
- HEARING LOSS
- HEPATITIS
- HIGH BLOOD PRESSURE
- HIV/AIDS
- HIGH CHOLESTEROL
- THYROID PROBLEMS
- LEUKEMIA
- LUNG CANCER
- LYMPHOMA
- PROSTATE CANCER
- RADIATION TREATMENT
- SEIZURES
- STROKE

PAST SURGICAL HISTORY -PLEASE CIRCLE ALL THAT APPLY

- JOINT REPLACEMENT WITHIN LAST 2 YEARS
- KNEE – JOINT REPLACEMENT
- HIP – JOINT REPLACEMENT
- CORONARY ARTERY BYPASS
- MECHANICAL VALVE REPLACEMENT
- BIOLOGICAL VALVE REPLACEMENT
- HEART TRANSPLANT

SKIN DISEASE HISTORY -PLEASE CIRCLE ALL THAT APPLY

- ACNE
- ACTINIC KERATOSES
- ASTHMA
- BASAL CELL SKIN CANCER
- BLISTERING SUNBURNS
- DRY SKIN
- ECZEMA
- FLAKING OR ITCHY SCALP
- HAY FEVER/ALLERGIES
- MELANOMA
- PRECANCEROUS MOLES
- PSORIASIS
- SQUAMOUS CELL CARCINOMA

DO YOU HAVE A FAMILY HISTORY OF MELANOMA? YES NO IF YES, WHICH RELATIVE(S):_____

PLEASE LIST ALL MEDICATIONS THAT YOU CURRENTLY TAKE _____

_____

_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? YES NO IF YES, LIST THE MEDICATION AND YOUR REACTION:

_____

SOCIAL HISTORY -PLEASE CIRCLE ALL THAT APPLY

CIGARETTE SMOKING: CURRENTLY SMOKES FORMER SMOKER NEVER SMOKED

ALCOHOL USE: NONE LESS THAN 1 DRINK PER DAY 1-2 DRINKS PER DAY 3 OR MORE DRINKS PER DAY

ALERTS + ALLERGIES -PLEASE CIRCLE ALL THAT APPLY

- ALLERGY TO ADHESIVE
- ALLERGY TO LIDOCAINE
- ALLERGY TO TOPICAL ANTIBIOTICS
- BLOOD THINNERS
- DEFIBRILLATOR
- PACEMAKER
- REQUIRE ANTIBIOTICS PRIOR TO SURGY
- PREGNANT OR NURSING

PHARMACY:_____**PRIMARY CARE PHYSICIAN:**_____

WHEN DID YOU LAST SEE YOUR PRIMARY CARE PHYSICIAN?_____

CONSENT FOR TREATMENT

KNOWING THAT I AM EXPERIENCING A CONDITION THAT MAY REQUIRE DIAGNOSTIC, MEDICAL OR SURGICAL TREATMENT, I DO HEREBY VOLUNTARILY CONSENT TO SUCH PROCEDURES AND CARE AND TO SUCH MEDICAL SURGICAL OR OTHER SERVICES UNDER THE GENERAL AND SPECIAL INSTRUCTIONS OF S. SASHA JAZAYERI, MD, RICHARD BOTTIGLIONE, MD, CHRISTOPHER REX, MD, TERESA CORRIGAN, FNP, ASSISTANTS, DESIGNEE, OR OTHER DOCTOR AS IS JUDGED NECESSARY.

I ALSO ACKNOWLEDGE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF TREATMENT OR EXAMINATION BY S. SASHA JAZAYERI, MD, RICHARD BOTTIGLIONE, MD, CHRISTOPHER REX, MD, TERESA CORRIGAN, FNP. ANYONE WHO RECEIVES AN INJECTION OF ANY KIND, PROCEDURE OF ANY KIND, BIOPSY, OR SURGERY MAY HAVE THE POSSIBILITY THAT IT WILL RESULT IN A BROWN, RED, WHITE, OR DEPRESSED SCAR APPEARING IN THE AREA. I UNDERSTAND THAT THE POTENTIAL RISKS AND BENEFITS OF SURGERY INCLUDE THE RISK OF INFECTION, BLEEDING, INJURY TO NERVES, POSTOPERATIVE STIFFNESS AND PAIN, AND FAILURE OF THE SURGERY TO ACHIEVE ITS INTENDED GOALS. AN INFECTION IS USUALLY VERY SWOLLEN SKIN, WHICH SHOULD BE REPORTED TO THE OFFICE IMMEDIATELY. I GIVE CONSENT FOR ANY PICTURES TO BE TAKEN FOR MEDICAL DOCUMENTATION PURPOSES.

I ACKNOWLEDGE THAT TREATMENTS, INCLUDING CHEMICAL PEELS (TCA SOLUTION), MAY RESULT IN REDNESS, DRYNESS, PEELING SKIN, AND POSSIBLE CHEMICAL BURNS, WHICH SHOULD IMPROVE OVER TIME.

PLEASE BE ADVISED THAT IF YOU DO NOT WISH TO SIGN THIS CONSENT FORM, THE DOCTORS AND/OR THEIR ASSISTANTS WILL NOT BE ABLE TO TREAT YOU FOR ANY CONDITION. ALLIANCE DERMATOLOGY MAY SHARE CERTAIN MEDICAL INFORMATION WITH YOUR PRIMARY CARE PROVIDER OR SPECIALIST AND YOU CONSENT US TO DOING SO.

PATIENT SIGNATURE:_____**DATE:**_____