MARJAN YOUSEFI, M.D.

CLINICAL & COSMETIC DERMATOLOGY

Today's Date _____/_____/_____

Last Name _____ **First Name** _____ **Middle** _____

Date of Birth _____/_____/_____

Social Security Number _____

Home Address_____

Apartment Number _____

City _____ **State** _____ **Zip Code** _____

Telephone Home _____ **Work** _____ **Cell** _____

E-mail address_____

Emergency Contact _____ **Relationship** _____ **Phone #** _____

Gender □ Male □ Female □ Transgender

Marital Status □ Single □ Married □ Divorced □ Separated

Race □White/Caucasian □Black/African American □ Asian □ American Indian & Alaska Native
□ Native Hawaiian & Other Pacific Islander □ Other □ Declined to Specify

Ethnicity □ Hispanic □ Not Hispanic □ Declined to Specify

Authorization to leave detailed voice messages □ YES □ NO

Patient's Occupation _____

Patient's Employer _____ **City** _____ **State** ____ **Zip Code** _____

Primary Care Physician Name _____ **Phone #** _____

Preferred Pharmacy _____ **Phone #** _____

Responsible Party Information (if different from patient)

Who is the insured party? □Self □Spouse □Mother □Father □Other _____

Primary Insured _____ **DOB of the primary insured** _____

Primary Insurance _____ **ID #** _____ **Group #** _____

Secondary Insurance _____ **ID #** _____ **Group #** _____

How did you hear about us? □ Online □ Family/Friend □ Primary Care Doctor □ Insurance Site □ Google □ Yelp

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Patient's Medical History: (Circle All That Applies)

Abnormal Heart Condition	Kidney Problems	Hypertension/ Hypotension
Cancers (type:_____)	Liver Disease	Hyperthyroid / Hypothyroid
Depression	GERD/Reflux	Transplant (what type)
Diabetes	Hepatitis (If yes, which type: ___)	
Joint Replacement (what year)	HIV	

Other (If other please specify): _____

_____

Patient's Skin History: **(Circle All that Applies)**

Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Precancerous Moles

Cold Sores/Herpes Keloid Formation in Scars

Any History of Blistering Sunburns: _____ **Tanning Bed Use:** _____

PLEASE LIST ALL CURRENT MEDICATIONS: (if you have a list, please give it to the front desk to copy)

Name	**Dose**		**Frequency**
_____	_____mg	___ tablet/capsule	_____
_____	_____mg	___ tablet/capsule	_____
_____	_____mg	___ tablet/capsule	_____
_____	_____mg	___ tablet/capsule	_____
_____	_____mg	___ tablet/capsule	_____

Drug Allergies:

_____

Social History: Use of Tobacco: ____Daily ____Rarely ____Former ____Never

Use of Alcohol: ___<1/day ___1 to 2/day ___3+ daily

How many times in the past year, have you had more than 4-5 drinks in 1 day? _____

Flu Shot: ____**NO** _____**YES** (If yes, when was it administered) **Date:** ___/___/_____

Pneumonia Vaccine: ____**NO** _____**YES** (If yes, when was it administered) **Date:** ___/___/_____

Family Skin History: Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Precancerous Moles