



Pacific Dermatology
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Patient Personal Information

Patient (Mr. Mrs. Ms. Miss) Last _____ First _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Male Female

Home Phone _____ Cell Phone _____ Email _____

Please provide your e-mail address if you are interested in receiving information on the latest advances in skin care treatments.

E-mail _____

How did you hear about us?

Friend Physician Family member Website Other _____

Patient Medical Information

Family History

Has anyone in your family ever had any of the following? (please check all that apply)

- Diabetes
- Psoriasis
- Melanoma
- Systemic lupus erythematosus
- Vitiligo
- Non-melanoma skin cancer
- Scleroderma
- Asthma, eczema, or hives

Patient Social History

- Use of Alcohol Never Occasional Moderate Previous/quit _____
- Use of Tobacco Never Occasional Moderate Previous/quit _____
- Use of Recreational Drugs Never Occasional Moderate Previous/quit _____

The following questions are for female patients only.

Do you take oral contraceptives (OCCs)? Yes No

Are you pregnant? Yes No

Are you planning a pregnancy? Yes No

Skin Questionnaire

Do you have any of the following skin conditions:

- Sensitivity
- Dilated capillaries/redness
- Eczema
- Dermatitis
- Brown Spots/Pigmentation
- Breakouts/Acne
- Excessive Oiliness
- Excessive Dryness
- Cold Sore/Fever Blister

Please list any facial surgical procedures you have had.

Reason for today's visit

Please answer the following questions.

How do you feel about the general appearance of your skin?

- Good Would like some improvement Don't like the appearance of my skin

How much time do you spend in the sun?

- A lot Some Very little Used to spend a lot of time in the sun

How often do you use a tanning booth? Frequently Occasionally Never Previously used/quit

Do you have wrinkles or frown lines you would like to remove?

- Yes No If yes, where? _____

What is more important to you in your decision to have a physician-administered injectable treatment for lines, wrinkles, or folds?

- Results that appear immediately and last 1 year or Results that take effect over time and last 2 years

Do you have veins on your legs that bother you?

- Yes, painful Yes, cosmetic only No

Do you have diffuse redness or small vessels on your face?

- Yes No

Does your face become red when you eat spicy foods, consume alcohol, or get excited?

- Yes No

Do you break out regularly?

- Yes No If yes, where? _____

Do you experience excessive sweating?

- Yes No If yes, where? _____

Do you use a particular line of skincare products?

- Yes No If yes, which product line? _____

Have you ever used skincare products with alpha hydroxy, glycolic acid, retinol, or a hydroquinone?

- Yes No If yes, what strength? _____

Have you had any experience with dermal fillers, injectables, or other types of cosmetic procedures (microdermabrasion, laser treatments, etc.)?

- Yes No If yes, please specify _____

Have you ever had a chemical peel?

- Yes No If yes, when? _____

Do you regularly apply sunscreen?

- Yes Only when outside Rarely Never

Do you have problems with healing? Yes No Do you develop keloids (scars) after surgery? Yes No

Do you bleed easily? Yes No

Do you develop skin rashes in reaction to any of the following? (check all that apply)

- Medications Food Environment Other _____

Patient Signature _____

Date _____