University Skin Institute
Medical, Surgical, and Cosmetic Dermatology

650 University Avenue, Suite 200
Sacramento CA, 95825
Phone: (916) 571-5200
Fax: (916) 571-5099

New Patient Clinical Intake Form Pediatrics

Main reason for today's visit: _____

Qualities of your condition: ☐ Itching/flaking ☐ Pain/tenderness ☐ Burning/blistering

☐ Enlarging/Changing/Darkening ☐ No symptoms ☐ Other: _____

Severity of your condition: ☐ Mild ☐ Moderate ☐ Severe

Duration of your condition: _____ Days _____ Months _____ Years

Anything that makes your condition better/worse? Please explain: _____

Have you used any prescription medication for your condition? _____

Past Medical History: (please mark all that apply)

☐ Arthritis, Lupus, Autoimmune Disease

☐ Hepatitis B, Hepatitis C, HIV/Aids

☐ Blood transfusion, Bone Marrow, or Organ Transplant

☐ Anxiety, Depression, Eating Disorder, Psychological problems

☐ Asthma, Tuberculosis, COPD, Emphysema, Chest Disease

☐ Acid Reflux, GERD, Stomach Ulcers

☐ Faint Spells, Seizures, Stroke, Neurological Disease

☐ High or low blood pressure, High Cholesterol

☐ Heart Disease, Pacemaker, Valve Replacement, Atrial Fibrillation, Coronary Artery Disease

☐ Breast Cancer, Lung Cancer, Colon Cancer, Prostate Cancer, Leukemia, Lymphoma

☐ Radiation Treatment

☐ Diabetes, Thyroid Disease ☐ Kidney Disease, Prostatic Disease

☐ Liver Disease, Jaundice, Cirrhosis ☐ Migraines, Headaches, Chronic Pain

☐ Artificial Joints ☐ Anemia, Blood/Bleeding Disease

☐ Other: _____ ☐ _____

Pediatric History:

Gestational age at birth (in weeks)? _____

Maternal or Neonatal complications? _____

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Meeting Developmental Milestones? ☐ Yes ☐ No

Social History:

Who does the child live with? _____

Other caregivers? _____

Siblings/Their ages? _____

Do you smoke or drink alcohol? _____

Are you sexually active? _____

Have you had any surgeries in the past? (Please indicate dates):

_____

Skin Disease History: (Please mark all that apply)

☐ Acne, Acne Scarring

☐ Flaking, Itchy Scalp

☐ Dry Skin, Eczema

☐ Cold Sores/Fever Blisters/Oral Herpes/Genital Herpes

☐ Abnormal Moles

☐ Melanoma Skin Cancer

☐ Basal Cell Carcinoma or Squamous Cell Carcinoma

☐ Psoriasis

☐ Asthma/Hay Fever/Allergies

☐ Shingles

☐ Blistering Sunburns

☐ Actinic Keratoses

☐ Other Skin Disease: _____

Do you wear sunscreen? Yes/No

Do you have a family history of Melanoma? No ____ Yes _____ Which relative? _____

When was your last full skin exam? _____

Medications (Please enter all current medications):

_____

_____

Allergies (Please enter all allergies and the type of reaction you had):

Review of Systems: Are you experiencing any of the following symptoms TODAY?

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☐ Problems with healing or scarring (hypertrophic or keloid)		☐ Problems with bleeding
☐ Fever or chills	☐ Unintentional weight loss	☐ Immunosuppression
☐ Joint Aches	☐ Headaches	☐ Shortness of breath
☐ Chest Pain	☐ Abdominal Pain	☐ None

To help us provide you with the safest treatments, please mark all that apply:

- Pregnant/breastfeeding or Planning a Pregnancy ☐ Yes ☐ No
- History of MRSA/resistant staphylococcus infection ☐ Yes ☐ No
- History of or exposure to HIV infection ☐ Yes ☐ No
- History of or exposure to Hepatitis B or Hepatitis C ☐ Yes ☐ No
- Allergy to any of the following? ☐ Adhesives ☐ Lidocaine ☐ Topical Antibiotics ☐ None
- Do you get rapid heart-beat with epinephrine (eg. numbing, injections, etc)? ☐ Yes ☐ No
- Do you have a defibrillator, pacemaker, artificial heart valve, or artificial joint placements? ☐ Yes ☐ No
- Are you required to take antibiotic premedication prior to surgical procedures? ☐ Yes ☐ No
- Are you on any blood thinners? ☐ Yes ☐ No

Credit Card Policy:

This policy is perfectly compatible with all the insurance contracts, as no usual payments are asked for at the time of the visit. We will change your credit card for co-pays. Also, when the explanation of benefits comes in from your insurance(s) we will then bill you for the balance deemed owned by you, the patient, for any amount up to $100. This will avoid any collection actions or fees to apply to your account. **For any charges above $100, we will contact you prior to charging your credit card.** This information will be in a secure location and will not be in your chart. Our office will only use this information for collection purposes. We appreciate your understanding and cooperation.

☐ Mastercard ☐ Visa ☐ Discover

Credit card number: _____ Exp. Date: ____/_____
Signature Code: _____
Name as it appears on card (please print): _____

Signature of cardholder: _____ Date: _____/_____/_____

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CONSENT TO MEDICAL CARE & TREATMENT OF MINOR CHILDREN:

I, _____, the natural/legal guardian of _____, authorize and consent to medical and surgical care, treatment and procedures to be performed for my child by a licensed physician/provider. In the sole discretion of the attending physician/provider, such care, treatment and procedures are necessary or advisable in the interest of my child's health and well being. This consent is valid until I have notified Pantea Hashemi MD that this policy has been revoked.

Patient/Responsible party's signature: _____
Date: _____/_____/_____