Peraza Dermatology Group

Telephone: 603.542.6455|Facsimile: 603.543.0736 www.perazaderm.com
José E. Peraza, M.D., F.A.A.D. | **Daniel M. Peraza, M.D., F.A.A.D.**
Kira Schachinger P.A.-C | **Ashwin L. Kumar, P.A.-C** | **Elisabeth Neal P.A.-C**

Name: _____ Email: _____Date of birth: _____ ☐Male ☐Female

If we need to call you, may we leave detailed personal medical information (such as test results) on your voicemail? ☐Yes ☐No

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone: _____Relationship: _____

Primary Care Physician and Address: _____

Pharmacy Name and Address: _____

How did you hear about us: ☐Online search ☐Facebook ☐Instagram ☐Twitter ☐Newspaper ☐Word-of-mouth ☐Work in this building/complex ☐Insurance website ☐Referred by physician named: _____ ☐Other: _____

What is the reason for your visit? _____

Please circle or list any medical conditions you have been diagnosed with:

Acne	Cold Sores	Heart Murmur	Implanted Metal
Anxiety	Depression	Hepatitis B or C	Pacemaker
Artificial Joints	Diabetes	High Blood Pressure	Seizures
Bleeding Disorders	Eczema	HIV/AIDS	Skin Cancer (list type)

_____

Has anyone in your family had a skin cancer? Who and what type of skin cancer? _____

What prescription medicines, over the counter supplements, and vitamins do you currently take? _____

_____

Medication allergies: _____

Have you ever taken isotretrinoin (aka Accutane)? ☐Yes ☐No When? _____

Do you use Retin-A, Renova, Adapalene, Differin, Tazarotene, Tazorac, Tri Luma, Green Cream or other retinol products ☐Yes ☐No

Do you have a fever today: ☐Yes ☐No
Do you have excessive bleeding? ☐Yes ☐No
Do you develop keloid scars? ☐Yes ☐No
Do you get GI upset from antibiotics? ☐Yes ☐No
Do you have nausea today? ☐Yes ☐No
Are you tan now? ☐Yes ☐No
Do you use tanning beds? ☐Yes ☐No
Do you get yeast infection from antibiotics? ☐Yes ☐No
When were you last in the sun? _____

Smoking status: ☐Current smoker ☐Former smoker ☐Never smoker

For female patients: Are you pregnant or trying to get pregnant? ☐Yes ☐No Breastfeeding? ☐Yes ☐No

I would like to discuss the following (circle all that apply):

Acne scarring	Coolsculpting (fat removal)	Redness on face
Botox	Laser for tattoo removal	Skincare
Brown spots	Laser hair removal	Veins on face
Chemical peels	Laser resurfacing	Emsculpt
Filler injections	Microneedling	Other: _____

Please list all previous cosmetic procedures/surgeries you have had:

_____

Patient signature: _____ Date: _____

Provider signature: _____ Date: _____