Laser & Skin Surgery Center of New York®

RESEARCH DEPARTMENT

Today's date:			
PATIENT INFORMATION			
Last:	First:		Middle:
Soc. Sec. #:	Date of Birth:	Age:	Sex:
Address:		Apt #:	
City:	State:	Zip Code:	
Home Phone:	Cell Phone:		
Email Address:			
Would you like to receive email correspondence about future clinical trials? ☐ YES ☐ NO			
Employer:	Work Phone:		
Address:	Occupation:		
CONTACT INFORMATION			
Emergency Contact Name:	Relationship:		
Home Phone:	Cell Phone:		
Primary Care Physician:	Phone #:		
Pharmacy:	Phone #:		
ADDITIONAL INFORMATION			
Have you ever been to our center before? ☐ YES ☐ NO If yes, for what reason:			
Do you have any serious health conditions? ☐ YES ☐ NO If yes, please list:			
Do you have any allergies? ☐ YES ☐ NO If yes, please list:			
Do you smoke? ☐ YES ☐ NO If yes, frequency:			
Do you drink alcohol? ☐ YES ☐ NO If yes, frequency:			
Do you use recreational drugs? ☐ YES ☐ NO If yes, frequency:			

To help give the best possible care, please carefully complete all questions on this form.
If unaware of an answer, leave it blank. PLEASE CHECK 'YES' OR 'NO'

Do you currently or have you ever been under the care of a physician for the following:	**YES**	**NO**	If yes, please describe (ie: condition, date diagnosed/treated, treatment type)
- Cardiovascular			
- Gastrointestinal			
- Endocrine / Hormonal			
- Infectious (HIV, AIDS, hepatitis etc.)			
- Blood Disorders			
- Muscoskeletal			
- Neurological			
- Psychiatric			
- Cancer			
Have you ever had:			
- Eczema			
- Psoriasis			
- Photosensitive reactions (lupus)			
- Excessive bleeding when cut			
- Overgrown scars/keloids			
- Allergy to local anesthetics			
- Allergy to latex			
- Gold therapy treatments			
- Grenz or x-ray treatment to your skin			
Have you ever had a blood transfusion?			
Do you have a history of cold sores?			
Have you taken Accutane in the last year?			

Please list prior cosmetic procedures, surgeries or hospitalizations with approximate dates:

_____

_____

_____

_____

Please list your medications, drugs, or over the counter preparations/remedies?

MEDICATION	INDICATION	DATE STARTED	DOSAGE (Milligrams)	HOW OFTEN

When you go into the sun without a tan, you…	**Race or ethnicity:**	
___Burn easily, never tan	__ Caucasian	__ Middle Eastern
___Burn easily, tan minimally with difficulty	__ African-American	__ Pacific Islander
___Burn moderately, tan moderately & uniformly	__ Hispanic or Latino	__ Native American
___Rarely burn, tan profusely	__ Asian	__ Other: _____
___Never burn, tan profusely	__ More than one race	__ Do not identify

Have you previously had a skin problem or been under the care of a dermatologist? ☐ YES ☐ NO
If yes, please describe (include dates under care):

_____

_____

FOR WOMEN ONLY	**YES**	**NO**
Are you pregnant?		
Are you currently breastfeeding?		
Are you currently planning a pregnancy?		

NOTE: The dermatologic examination which you are about to receive is not a complete physical examination. It is suggested that you have a complete physical examination periodically by your family physician or internist.

SIGNATURE: _____ DATE: _____

REVIEWED BY: _____ DATE: _____

FOR OFFICE USE ONLY	
STUDY NAME:	SCREENED BY:
PATIENT SKIN TYPE:	
ACCEPTED REJECTED PENDING reason:	

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_____	_____	_____
Patient Name (Printed)	Patient Signature	Date
_____	_____	_____
Witness Name (Printed)	Witness Signature	Date

For use by LSSC Personnel Only

Camera Height: _____cm Light Setting: **F** **B** Zoom: _____

Notes: _____

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