Michael H. Tirgan, MD

23 West 73rd street, # GD, New York, NY 10023

Keloid Consultation Intake Form

Please complete and forward this form, along with images of your keloid(s), to **DrTirgan@gmail.com.**

First Name: MI: Last Name:

Gender: Date of Birth:

Address:

City: State: Zip:

Cell Phone: Home phone:

Email: Occupation:

1. Please list the approximate size and location of all your keloids:	
2. How long have you had keloid?	
3. At what age did you first notice this condition?	
4. Has there been any recent change in the rate of growth/shape or looks of the lesion(s)?	
5. Have you ever had surgery for your keloid? If yes, state the date(s) of surgery:	

6. Have you ever had steroid injections? If yes, please state dates and number of injections	
7. Have you received radiation? If yes, please state dates:	
8. Have you received any other treatments? If yes, please state type of treatments and dates:	
9. Have you ever been diagnosed with skin cancer or Melanoma?	
10. Does anyone in your family has keloid?	
11. Please list any other medical condition(s) that you may have?	
12. Please list all medications you are taking.	
13. Ethnicity (please mark one):	African American ☐ Caucasian ☐ SE Asian (China/Japan/etc.) ☐ Hispanic ☐ Indian ☐ Other ☐ Pakistani ☐ Middle Eastern ☐

Do you have: Asthma	Yes ☐	No ☐
Chronic Rhinosinusitis with Nasal Polyposis	Yes ☐	No ☐
Eczema/Atopic Dermatitis	Yes ☐	No ☐
Other relevant information:		

To better understand the natural history of keloid disorder and to improve patients' outcomes, Dr. Tirgan constantly analyzes the treatment results of all his patients. In order to formally conduct this process, i.e., research in natural history and the treatment outcomes, and be able to publish these results and share any such results, Dr. Tirgan needs your consent.

The clinical research that is conducted by Dr. Tirgan is limited to review of all clinical information about his patients, and review of the photographs that he takes during each visit. To allow Dr. Tirgan to do this clinical research and share the results of any such research with the medical community, Dr. Tirgan requests that you please read the consent form below and hopefully allow Dr. Tirgan to analyze any data that he collects during each visit that you come to his office. This research is done anonymously, and your identity is fully protected.

If you agree for Dr. Tirgan to review your records, please sign the short consent form below.

I, (your full name:) hereby authorize Dr. Michael Tirgan to review all my existing medical records and images of my keloids that he has in his possession for purposes of keloid research and publishing of the results of such analysis in medical journals, and presenting the same in medical conferences and meetings.

Sign: Date: