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:				

Sign: Date: