mays

DERMATOLOGY & COSMETIC CENTER

Patient Medical History

Patient Name: _____ DOB: _____ / _____ / _____

Reason for today's visit: _____

_____

Is this a new or chronic condition: _____

List of Medical Health Problems (including those for which you are not taking medication)

Check if you are on **NO MEDICATIONS**: ☐

Condition	Medication

Do you have **DRUG ALLERGIES**? □ No □ YES

If yes, please specify type and reaction: _____

Are you currently **PREGNANT**? □ No □ YES

Are you currently **Breastfeeding**? □ No □ YES

List all significant hospitalization(s) and/or surgical procedure(s):

Description	Month/Year

Would you like to receive skin care and procedure recommendations during your visit? **Y** **N** If yes please list your current skin care here and check all that apply: _____

_____

_____

Please circle any areas of concern:

Facial lines/wrinkles	Pore size
Scars/Acne Scars	Hair loss/thinning
Acne/Breakouts	Eyelid drooping
Skin redness/irritation	Sensitive skin
Brown spots/discoloration	Thin Eyebrows
Length/Fullness of eyelashes	Dull skin texture
Unwanted/excess hair	Excessive sweating
Stretch marks	Double chin
Spider Veins	Body Fat

Family Medical History □ Unknown

Mother: Alive Deceased Father: Alive Deceased

Family history of skin cancer: □ No □ Yes

Do you have a history of skin cancer? □ No □ Yes

Type and location:

_____

Personal/Social Habits and History:

Do you use tobacco products?	□ No	□ Yes
Do you drink alcohol?	□ No	□ Yes
Do you use recreational drugs?	□ No	□ Yes
Have you been exposed to HIV?	□ No	□ Yes
Have you been exposed to Hepatitis?	□ No	□ Yes
Amount of daily sun exposure:	□ Low	□ Med □ High
Do you use sunscreen?	□ No	□ Yes
Do you use tanning beds?	□ No	□ Yes

Other Medical Information:

Do you have dry or sensitive skin?	□ No	□ Yes
Do you have a pacemaker or defibrillator?	□ No	□ Yes
Do you tend to develop keloids?	□ No	□ Yes
Are you allergic to tape or bandages?	□ No	□ Yes
Are you allergic to topical antibiotics?	□ No	□ Yes
Do you take aspirin or meds to thin your blood?	□ No	□ Yes
Do you have problems with your immune system?	□ No	□ Yes
Do you experience excessive sweating?	□ No	□ Yes
Do you have bleeding problems?	□ No	□ Yes
Do you have problems with your finger/toe nails?	□ No	□ Yes

mays

DERMATOLOGY & COSMETIC CENTER

PATIENT INFORMATION

_____ □ M □ F

LAST NAME | FIRST NAME | MIDDLE INITIAL | GENDER

_____

HOME ADDRESS: NUMBER AND STREET NAME | APT/UNIT #

_____

CITY | STATE | ZIP CODE

_____

PRIMARY PHONE NUMBER | DATE OF BIRTH | **SSN #**

_____ Brilliant Distinctions or Aspire Member? ☐ YES ☐ NO

EMAIL ADDRESS

RESPONSIBLE PARTY: _____ IF SAME AS ABOVE PLEASE INITIAL: _____

ADDRESS: _____ RELATIONSHIP: _____

SSN: _____ **DOB:** _____ PHONE #: _____

PHARMACY & PHYSICAN INFORMATION

PHARMACY NAME | PHARMACY ADDRESS | PHARMACY PHONE NUMBER

_____

PCP: _____ **Referring Physician:** _____

PRIMARY INSURANCE INFORMATION

COPY OF INSURANCE CARDS ARE REQUIRED ARE YOU THE INSURED OR A DEPENDENT? □ INSURED □ DEPENDENT

_____

PRIMARY INSURANCE: CLAIMS PHONE #:

SECONDARY INSURANCE INFORMATION

COPY OF INSURANCE CARDS ARE REQUIRED ARE YOU THE INSURED OR A DEPENDENT? □ INSURED □ DEPENDENT

_____

SECONDARDY INSURANCE: CLAIMS PHONE #:

EMERGENCY CONTACT INFORMATION

IS CASE OF EMERGENCY WHO SHOULD WE CONTACT?

NAME: _____ PHONE #: _____ RELATIONSHIP: _____

HIPAA

Please list names and relationships of persons with whom we may discuss your medical care (if any) and whether messages can be left on your phone. **SELF ONLY: Can Leave Message: Y N**

Name:_____ Phone #:_____ Relationship: _____

Name:_____ Phone #:_____ Relationship: _____

SIGNATURE

_____

PATIENT/GUARDIAN SIGNATURE **DATE:**

I HEREBY AFFIRM THAT I AM THE PATIENT OR LEGAL GUARDIAN OF THE PATIENT AND HAVE AUTHORITY TO MAKE DECISIONS REGARDING MEDICAL TREATMENTS.