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 & check all that apply below: _______

____

____

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

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.