INTEGRATED
DERMATOLOGY
OF NORTH RALEIGH

Willis Martin, M.D. • Angela Macri, D.O.

HEALTH QUESTIONNAIRE

Date: _____

Name: _____ Age: _____ Date of Birth: _____

Referred By: _____

Primary Care Physician: _____ Phone: _____

Primary Reason for Your Visit: _____

_____

Duration of Problem: _____

Treatment: _____

Aggravating Factors: _____

Current Medications (please include over-the-counter, herbs, vitamins, supplements): _____

_____

_____

Allergies to Medication: ☐None ☐ _____

Other Allergies: ☐None ☐Latex ☐Bandages/Adhesive

☐Topical Antibiotic (Neosporin or other) _____

Have you ever had a bad reaction to local anesthesia? ☐No ☐Yes ☐Never had anesthesia

FOR WOMEN ONLY:

Are you currently pregnant, trying to become pregnant, or are you nursing? _____

Are you on a contraceptive, and if so, what form? _____

SKIN CONDITIONS:

Have you ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Where? _____ When? _____

Treatment? _____

Has anyone in your family ever had skin cancer? ☐No ☐Yes

If Yes, ☐Basal Cell Cancer ☐Squamous Cell Cancer ☐Melanoma

Who? _____

Integrated Dermatology of North Raleigh
3809 Computer Drive, Suite 200, Raleigh, NC 27609
Phone: (919) 782-3784 • Fax: (919) 782-3788

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Do you have any history of skin problems or diseases? ☐No ☐Yes

If Yes, ☐Psoriasis ☐Eczema ☐Keloid ☐Other _____

SUN EXPOSURE:

When you are exposed to the sun do you:

☐ always burn
☐ usually burn, tan minimally
☐ sometimes mild burn, tan uniformly
☐ rarely burn, always tan well
☐ very rarely burn, tan very easily
☐ never burn, tan very easily

Where did you grow up? _____

Did you: ☐ sunburn every summer in childhood
☐ get at least one blistering sunburn, how many _____
☐ ever use a tanning bed, how many times/how often _____

Do you: ☐ Use sunscreen regularly, SPF _____

PAST SURGERIES (Type and Date): _____

_____

_____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Allergic/Immunologic: ☐Normal ☐Seasonal allergies ☐Immunosuppression ☐Autoimmune problem

Constitutional: ☐Normal ☐Weight loss/weight gain ☐Fever/Night sweats ☐Fainting

Cancer: Type _____

Cardiovascular: ☐Normal ☐Artificial Heart Valve ☐Pacemaker ☐Implanted Defibrillator ☐Irregular Heartbeat ☐Chest Pain/Heart attack ☐Mitral Valve Prolapse ☐Other _____

Ears/Eyes/Nose: ☐Normal ☐Glaucoma ☐Glasses/Contacts ☐Other _____

Endocrine: ☐Normal ☐Diabetes ☐Thyroid Disease ☐Other __ Gastrointestinal: ☐Normal ☐Reflux ☐Liver Problem ☐Nausea ☐Diarrhea ☐Other _____

Genital/Urinary: ☐Normal ☐Enlarged Prostate ☐Prostate Cancer

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Hematologic: ☐Normal ☐Anemia ☐Bleeding Problems ☐Other _____

Infections: ☐Normal ☐HIV ☐Hepatitis ☐Tuberculosis/+PPD Skin Test

☐Other _____

Musculoskeletal: ☐Normal ☐Arthritis ☐Artificial Joint ☐Other _____

Neurological: ☐Normal ☐Stroke ☐Seizures/Epilepsy ☐Multiple Sclerosis

☐Other _____

Respiratory: ☐Normal ☐Asthma ☐Emphysema ☐Other _____

Psychiatric: ☐Normal ☐Depression ☐Anxiety Attacks ☐Other _____

Others: ☐Kidney Problems ☐Cold Sores ☐Varicose Veins

☐Require Antibiotics Prior to Dentistry

Any other medical problems: _____

FAMILY HISTORY: ☐Eczema ☐Psoriasis ☐Other _____

COSMETIC HISTORY: ☐BOTOX Injectable Fillers ☐Laser Treatments

SOCIAL HISTORY:

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/Widower

Occupation:

_____

Smoking: ☐No ☐Former ☐Yes, packs/day _____

Alcohol: ☐No ☐Yes, how much/often _____

By signing, I am acknowledging that I have disclosed all of my health information known to me at this time, and all of my other personal information is accurate. I understand that it is my obligation and responsibility to notify Integrated Dermatology of North Raleigh of any changes in my medical information during the course of my medical treatment.

SIGNATURE _____ Date _____

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HIPPA Patient Consent Form

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. This Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

This Consent was signed by: _____

Patient Name – Patient Representative

_____ / / /

Signature Date

Relationship to Patient
(if other than patient) _____

Witness: _____

Patient Name – Practice Representative

_____ / / /

Signature Date

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HIPAA Release of Information

Messages regarding office appointments may be left on my:

☐ Cell phone ☐ Home phone ☐ Work phone
☐ Email ☐ Sent as text to cell

Messages regarding information related to my care may be left on my:

☐ Cell phone ☐ Home phone ☐ Email

It is okay to discuss my health information with:

_____

_____

_____

This HIPPA Release of Information was signed by:

_____
Printed Name – Patient or Representative

_____ _____
Signature Date

Relationship to Patient
(if other than patient):_____

_____

Preferred Pharmacy

Pharmacy Name _____

Address _____

City, State, Zip Code _____

Phone Number _____

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