INTEGRATED DERMATOLOGY OF CLINTON

PATIENT INFORMATION				Date		
LAST NAME	FIRST NAME	MI		BIRTHDATE		
HOME ADDRESS	CITY		STATE	ZIP		SEX: ☐MALE ☐FEMALE
MOBILE #	HOME #		Best number to call with test results			
EMAIL ADDRESS						
PRIMARY CARE PHYSICIAN						
REFERRING PHYSICIAN						

RESPONSIBLE PARTY INFORMATION (If other than self)

LAST NAME	FIRST NAME	MI	BIRTHDATE

RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE ☐ SON ☐ DAUGHTER

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER	
OCCUPATION	WORK #

MEDICAL INFORMATION RELEASE

May we leave test results on your answering machine ? ☐Yes ☐No

Do you give permission to discuss your medical information with anyone other than self? ☐Yes ☐No

If yes, who?

EMERGENCY CONTACT INFORMATION

NAME		RELATIONSHIP		Best number to call
ADDRESS	CITY	STATE	ZIP	Alternate number to call

PHARMACY INFORMATION-Must provide complete address information to ensure your prescriptions are sent to the correct pharmacy.

PHARMACY NAME	ADDRESS

NOTICE OF PRIVACY PRACTICES:

My signature below acknowledges I have received a copy or a copy has been made available to me of the Integrated Dermatology of Clinton NOTICE OF PRIVACY PRACTICES.

SIGNATURE	DATE

HEALTH QUESTIONNAIRE

SOCIAL HISTORY

Do you wear sunscreen? ☐No ☐Yes What level SPF? ____________________

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

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

Vaccinations received within the year ☐FLU ☐PNEUMONIA

IMPORTANT MEDICAL QUESTIONS

Are you taking blood thinners? ☐Yes ☐No

Do you have a Pacemaker or Defibrillator? ☐Yes ☐No

MEDICATIONS & ALLERGIES

PLEASE LIST ALL MEDICATIONS (PRESCRIPTION & OVER THE COUNTER)

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐No ☐Yes If yes, please list: ______________

Are you allergic to local anesthetics? Novocaine ☐No ☐Yes Lidocaine ☐ No ☐Yes

If yes, do you experience rapid heart rate with Epinephrine? ☐ No ☐ Yes

Are you taking medication that could cause immunosuppression? (Prednisone, Methotrexate, Biologics/Injectable Medications, Chemotherapy) ☐No ☐Yes

MEDICAL HISTORY

DO YOU HAVE NOW, OR HAVE YOU HAD ANY OF THE DISEASES OR CONDITIONS LISTED BELOW? PLEASE CHECK ALL THAT APPLY

- ☐ SEASONAL ALLERGIES/HAY FEVER
- ☐ HIGH CHOLESTEROL
- ☐ EMPHYSEMA (COPD)
- ☐ ASTHMA
- ☐ STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ CHEST PAIN
- ☐ HEART SURGERY
- ☐ MITRAL VALVE PROLAPSE
- ☐ HEART ATTACK
- ☐ HEART MURMUR
- ☐ IRREGULAR HEARTBEAT
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ BLOOD CLOTS
- ☐ BIPOLAR DISEASE
- ☐ CANCER(TYPE) ______________
- ☐ HIV(AIDS)
- ☐ HERPES SIMPLEX VIRUS
- ☐ DIABETES
- ☐ THYROID
- ☐ PROSTATE
- ☐ KIDNEY
- ☐ BLADDER
- ☐ STOMACH/ ULCERS
- ☐ COLON/BOWEL DISEASE
- ☐ HEPATITS
- ☐ EYE DISORDER
- ☐ ARTHRITIS
- ☐ SEIZURES
- ☐ TUBERCULOSIS
- ☐ JOINT REPLACEMENT

MEDICAL HISTORY CONT.

PAST SURGERIES (Within 5 years): ______________

____

____

Are you pregnant or planning a pregnancy ? ☐No ☐ Yes

Are you currently nursing? ☐ No ☐Yes

Are currently on a contraceptive, and if so, what form? ☐ No ☐Yes ______________

DERMATOLOGICAL HISTORY

HAVE YOU HAD SKIN CANCER? ☐No ☐ Yes

If yes which type? ☐Melanoma ☐Basal Cell Cancer ☐Squamous Cell Cancer

Has anyone in your family had skin cancer? ☐No ☐Yes If yes, who? ______________

If yes, which type? ☐Melanoma ☐Basal Cell Cancer ☐Squamous Cell Cancer

Do you have a history of any specific skin problems? ______________

If yes, has this been previously treated? ☐No ☐Yes If yes, with which medications/ procedures?

____

____

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 Clinton of any changes in my medical information during the course of my medical treatment.

SIGNATURE ______________ Date ______________