

PATIENT HISTORY FORM

Name: _____ Date Of Birth: _____

Primary Care Physician: _____ Did they refer you to this office? Yes No

Month and year of last visit: _____

Race: Caucasian African American Asian Other _____

Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Preferred Language: Spanish English Other _____

Current Medical Problem You Are Here For Today: _____

Personal Past Medical History: (Please circle all that apply)

Anxiety/Depression	Heart Valve Replacement	Lymphoma
Arthritis, Rheumatoid or Psoriatic	Hepatitis	Pacemaker
Artificial joints	High Blood Pressure	Radiation Treatments
Asthma/COPD	High Cholesterol	Seizures
Cancer (type): _____	HIV	Stroke
Diabetes	Hypothyroidism	NONE OF THE ABOVE

GERD
Other: _____

Past Surgical History and Hospitalizations: (List all) _____

Skin History: (Please circle all that apply)

Acne	Eczema	Precancerous moles
Actinic Keratosis	Flaking or Itching Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Seasonal Allergies	Squamous Cell Skin Cancer
Bleeding/Bruising	Keloid Scars	Sunburn(blistering)
Dry Skin	Melanoma Skin Cancer	NONE OF THE ABOVE

Other: _____

(Please list the location of all skin cancers you may have had.) _____

Do you wear sunscreen? Yes No If yes, SPF? _____ Do you use indoor tanning? Yes No Never

Medications: (Please enter all current medications including vitamins or supplements) No Medications

Do you have allergies to medications? Yes No No Allergies

If yes, please list and give type of reaction: _____

Do you smoke? (circle one) Current (Packs per day) _____ Former Never

Number of alcoholic drinks per day. (circle one)
None Less than 1 per day 1-2 per day 3 or more per day

Preferred Pharmacy: _____

I consent to give Dermatology Clinic of Iowa PC permission to obtain medication information from my pharmacy.

Yes No

(over)

Alerts: (Please circle all that apply)

Allergy to Adhesive or Lidocaine
Allergy to Topical Antibiotics
Blood Thinner
Bone Marrow Transplant
Defibrillator
Healing Problems

MRSA
Pacemaker
Pregnancy or Planning Future Pregnancy
Rapid Heart Rate With Epinephrine
Require Antibiotics Prior To Surgical Procedure
Other _____

Family Medical History: (Please circle all that apply for first degree relative)

Melanoma: Father Mother Sister Brother Daughter Son Other
Diabetes: Father Mother Sister Brother Daughter Son Other
Breast Cancer/Prostate Cancer: Father Mother Sister Brother Daughter Son Other
Heart Disease: Father Mother Sister Brother Daughter Son Other

If any, please describe _____

Privacy Practices at Dermatology Clinic Of Iowa PC

Communication:

It is the office policy of Dermatology Clinic Of Iowa PC not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate below, so that we may best serve you. By signing below, you authorize the following people to receive information regarding your treatment or care.

Spouse: Yes No
Parent: Yes No
Other: Yes No If yes, name and relationship _____

Please list acceptable ways for us to contact you:

Cell phone: May we leave a voice message at this number?	Yes	No
May we leave information with whomever answers the phone?	Yes	No
Home phone: May we leave a voice message at this number?	Yes	No
May we leave information with whomever answers the phone?	Yes	No
Work phone: May we leave a voice message at this number?	Yes	No
May we leave a message with whomever answers the phone?	Yes	No

Acknowledgement of Privacy Practices of Dermatology Clinic Of Iowa PC (HIPAA)

Patient Name (please print): _____

I hereby acknowledge that I am aware of Dermatology Clinic Of Iowa PC's Notice of Privacy Practices, and have seen a summary of this notice. I acknowledge that I may have a copy of this notice upon request.

Signature: _____ **Date:** _____

Name of person completing this form if other than patient. (please print): _____

Relationship to Patient: (circle one) Parent Legal Guardian Other _____