



# **Dermatology Medical History**

Patient: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?  YES  NO if yes, list below:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**Have you ever had any dental anesthesia (novacaine)?**  YES  NO Any bad reaction?  YES  NO

List ALL the medications you are currently taking (includes prescribed meds, over the counters vitamins, herbals)

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have now, or ever had diseases or conditions of: (Please check YES or NO)

<b>Lungs</b>	<b>YES</b>	<b>NO</b>	<b>Other Systemic:</b>	<b>YES</b>	<b>NO</b>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
			Gastrointestinal		
			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular</b>	<b>YES</b>	<b>NO</b>	Nausea, vomiting, diarrhea,		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infections when taking		
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last 6 months: \_\_\_\_\_

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
<b>Skin:</b> Have you ever had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have problems with healing?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone in your family had skin cancer?	<input type="checkbox"/>	<input type="checkbox"/>	Do you develop keloids ( <i>scars</i> ) after surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a history of any specific skin diseases?	<input type="checkbox"/>	<input type="checkbox"/>	Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you develop skin rashes in reaction to: <input type="checkbox"/> Medications <input type="checkbox"/> Food <input type="checkbox"/> Environment <input type="checkbox"/> Bandages <input type="checkbox"/> Topical Neosporin					
<input type="checkbox"/> Other: _____					

**Social History:**

Do you drink alcohol?  YES  NO If YES \_\_\_\_\_ drinks per day  
 Do you use IV drugs?  YES  NO If YES, what? \_\_\_\_\_ How often? \_\_\_\_\_  
 Do you Smoke?  YES  NO If YES, how much: \_\_\_\_\_  
 Have you had or have you been exposed to HIV (AIDS)?  YES  NO  
 (Women) Are you pregnant?  YES  NO Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_  
 Completed by  Patient

Medical Assistant \_\_\_\_\_  
 \_\_\_\_\_ Initials Patient signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_\_ Reviewed by \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND  
SIGNATURE ON FILE**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Other family members that are patients: \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

In case of emergency, who should be notified? \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_ - \_\_\_\_\_

**Do you give our office permission to discuss your medical information with family members?**

YES  NO If yes, please provide their names and phone numbers below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: (    ) \_\_\_\_\_

**May we leave personal information on your answering machine at home?**     Yes  NO

**May we e-mail occasional promotional offers on products and services to you?**  Yes  NO

If yes, please provide your e-mail address: \_\_\_\_\_@\_\_\_\_\_

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PAYMENT POLICY:**

HMO, PPO, or other managed care patients: You will be responsible for paying your annual deductible, copayment and charges for any non-covered cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**WILDWOOD DERMATOLOGY, P.C.**

16516 Manchester Road

Wildwood, MO 63040

---

Anne T. Riordan, MD

**PATIENT STATEMENT OF RESPONSIBILITY**

I understand that certain health insurance plans require authorization given by my primary care physician for evaluation / treatment by a specialist. I also understand that certain procedures performed may not be covered by my insurance plan. I understand that there is a possibility that the evaluation / treatment rendered today may not be covered by my health plan. If they are not covered by my health plan, I agree to pay for those services which are not covered.

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_