MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

CURRENT MEDICATIONS TAKING (prescriptions, over-the-counter meds, vitamins, herbal treatments) *Use back of form if needed*

Name	Strength	Route	Dose	Frequency	Name	Strength	Route	Dose	Frequency

DO YOU HAVE, OR HAD ANY OF THE FOLLOWING CONDITIONS? *Check only those that apply & write Location/Date*

Past Medical History — *Area/Year*

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation _____
- ❑ Bone Marrow Transplantation _____
- ❑ BPH (prostate enlargement) _____
- ❑ Breast Cancer _____
- ❑ Colon Cancer _____
- ❑ Chronic Obstructive Pulmonary disease
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD (acid reflux, heartburn)
- ❑ Hearing Loss
- ❑ Hepatitis _____
- ❑ Hypertension
- ❑ HIV/AIDS _____
- ❑ Hypercholesterolemia _____
- ❑ Hyperthyroidism _____
- ❑ Hypothyroidism _____
- ❑ Leukemia _____
- ❑ Lung Cancer _____
- ❑ Lymphoma _____
- ❑ Prostate Cancer _____
- ❑ Radiation Treatment _____
- ❑ Seizures _____
- ❑ Stroke _____
- ❑ OTHER: _____

Skin Disease History

- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Asthma
- ❑ Basal Cell Skin Cancer _____
- ❑ Blistering Sunburn (s)
- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma _____
- ❑ Poison Ivy _____
- ❑ Precancerous Moles _____
- ❑ Psoriasis _____
- ❑ Squamous Cell Skin Cancer _____
- ❑ OTHER: _____

Medical conditions or recent surgery
(within last 6 months):

_____
_____
_____
_____

Past Surgical History — *Area/Year*

- ❑ Appendix Removed _____
- ❑ Bladder Removed _____
- ❑ Breast Biopsy (Right, Left, Both) _____
- ❑ Lumpectomy (R, L, B) _____
- ❑ Mastectomy (R, L, B) _____
- ❑ Colon Cancer Resection _____
- ❑ Colectomy: Diverticulitis
- ❑ Inflammatory Bowel Disease _____
- ❑ Gallbladder Removed _____
- ❑ Biological Valve Replacement _____
- ❑ Coronary Artery Bypass Surgery _____
- ❑ Heart transplant _____
- ❑ Mechanical Valve Replacement _____
- ❑ Heart: PTCA _____
- ❑ Hip Joint Replacement (R, L, B) _____
- ❑ Knee Joint Replacement (R,L,B) _____
- ❑ Kidney Biopsy
- ❑ Kidney Transplant _____
- ❑ Kidney: Nephrectomy _____
- ❑ Liver: Hepatectomy _____
- ❑ Liver Transplant _____
- ❑ Liver Shunt _____
- ❑ Ovaries Removed _____
- ❑ Ovarian Cancer Removed _____
- ❑ Ovarian Cyst Removed _____
- ❑ Tubal Ligation _____
- ❑ Pancreas: Pancreatectomy _____
- ❑ Prostate Biopsy
- ❑ Prostate Cancer _____
- ❑ Prostate: TURP _____
- ❑ Rectum: APR _____
- ❑ Skin: Basal Cell _____
- ❑ Skin: Melanoma _____
- ❑ Skin Biopsy _____
- ❑ Skin: Squamous Cell _____
- ❑ Spleen Removal _____
- ❑ Testicles Removal _____
- ❑ Hysterectomy: Fibroids _____
- ❑ Hysterectomy Uterine Cancer _____
- ❑ Hysterectomy Cervical Cancer _____
- ❑ OTHER: _____

Current Influenza Immunization: ❑Yes ❑No
We recommend yearly immunization

Vaccinated for Pneumonia: ❑Yes ❑No

Do you wear sunscreen? ❑ Yes: SPF___ ❑No

Do you go to a tanning salon? ❑ Yes ❑ No

Are you pregnant? ❑Yes:_____ ❑No ❑Maybe
Due date

Review of Systems (current symptoms)

- ❑ Fever or chills
- ❑ Unintentional weight loss
- ❑ Night sweats
- ❑ Immunosuppression (low immune system)
- ❑ Enlarged lymph nodes
- ❑ Problem with bleeding
- ❑ Problem with healing
- ❑ Problem with scarring (keloids)
- ❑ Rash
- ❑ New or Changing mole
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Cough
- ❑ Wheezing
- ❑ Sore throat
- ❑ Blurry Vision
- ❑ Thyroid problems
- ❑ Abdominal pain
- ❑ Bloody stool
- ❑ Bloody urine
- ❑ Joint aches
- ❑ Muscle weakness
- ❑ Neck stiffness
- ❑ Headaches
- ❑ Seizures
- ❑ Anxiety
- ❑ Depression

ALERTS

- ❑ Pacemaker
- ❑ Defibrillator
- ❑ Premedication before procedures
- ❑ Artificial heart valve
- ❑ Artificial joints within the past 6 months
- ❑ Allergy to lidocaine (Xylocaine)
- ❑ Rapid heartbeat with epinephrine
- ❑ Allergy to adhesive/tape
- ❑ Allergy to topical antibiotic ointments
- ❑ Blood thinners
- ❑ MRSA (staph infection)
- ❑ Pregnancy or planning pregnancy
- ❑ Hospice
- ❑ OTHER: _____

Do you know any "blood relative" who has/had melanoma? ❑ Yes ❑ No
Type & whom? _____
_____

Allergies: ❑ NONE (or list all Allergies)
_____
_____
_____

Patient Signature/POA/Guardian: _____ **Name:** _____ **Date:** _____
Form Completed by: ❑ **Patient** ❑ **Nurse/MA - Initials:**

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH / SERVICES INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____ SSN: _____

I. My Authorization

I authorize: Milam Bogart Dermatolgy, LLC

to use or disclose the following health or services information.

□ - All / Any of my health/services information

□ - My health information relating to the following treatment or condition:

_____

The above party may disclose this health information to the following recipients:

Name _____ Relationship _____

Name_____ Relationship _____

Signature of Patient: _____Date: _____

<u>If the patient is a minor or unable to sign, please complete the following</u>:

□ - Patient is a minor: _____ years of age

□ - Patient is unable to sign because: _____

Signature of Authorized Representative: _____

Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

□ - Parent □ - Legal Guardian □ - Court Order □ - Other: _____