PERSONAL HISTORY QUESTIONNAIRE

This information is confidential and will not be released

DERM Sa
MEDICAL
SURGICAL
COSMETIC

Name:_____ Date:_____

SS#_____ DOB:_____ Age ____ Sex: M F Marital status: _____

Address: _____ City _____ State _____ Zip _____

Primary Phone Number Cell/Home/Work_____ Email Address _____

(□ Yes, I would like to receive updates by email)

Purpose of this consultation _____ (*Required for educational and marketing purposes.)*

Primary Care Physician:_____ Referring Physician:_____

Date of last physical exam:_____ Height: _____ Weight: _____

Primary Insurance Co.		Secondary Insurance Co	
Responsible Party		Responsible Party	
SS#	Date of Birth	SS#	Date of Birth
Employer	Relationship	Employer	Relationship
Policy ID	Group #	Policy Id	Group #

PAST MEDICAL HISTORY: (*Please circle those that apply to you*)

Constitutional: Change in appetite, Chills/rigors, Decreased activity, Fatigue, Fever, Insomnia, Irritability, Lethargy, Malaise, Night Sweats, Pallor, Weakness, Weight gain, Other associated symptoms _____

HEENT: Eye discharge, Visual loss, Ear discharge, Hearing loss, Nasal drainage, Other associated symptoms _____

Respiratory: Accelerated respirations, Cough, Cyanosis, Dyspnea, Frequent upper respiratory infections, Hemoptysis, Painful urination, Snoring, Sputum, Stridor, Use of accessory muscles for respirations, Wheezing, Other associated symptoms _____

Cardiovascular: Chest pain, Edema, Nocturia, Nocturnal dyspnea, Orthopnea, Irregular heartbeat/palpitations, Syncope, Other associated symptoms _____

Vascular: Claudication, Cool extremity, Cyanosis, Edema, Erythema, Pain (vascular), Raynaud's, Thrombophlebitis, Ulcer, Varicose veins, Paresthesia, Other associated symptoms _____

Gastrointestinal: Abdominal mass, Abdominal pain, Bloating, Blood in stool, Change in bowel habits, Constipation, Diarrhea, Dysphagia, Fecal incontinence, Flatulence, Heartburn, Hematemesis, Hemorrhoids, Increased appetite, Jaundice, Melena, Nausea, Odynophagia, Rectal bleeding, Reflux, Vomiting, Weight loss, Other associated symptoms _____

Dermatologic: Acne, Contact allergy, Excessive diaphoresis, Excessive sun exposure, Frequent skin infections: Location: _____ Hair loss, Hirsutism, Nail changes, Photosensitivity, Pigment change, Pruritus, Rash, Change in mole, Skin Lesion, Other associated symptoms _____

Do you regularly smoke: Y N Never How much per day? _____

Do you regularly drink alcohol or beer: Y N Never How much per week? _____

MEDICATIONS: *(Please list current medications)* _____

_____

Do you take herbal supplements? Y N If yes, what are they? _____

DRUG OR SUBSTANCES TO WHICH YOU ARE ALLERGIC _____

TYPE OF REACTION: _____

FAMILY HISTORY: *(Please specify family member)*

Arthritis _____ Asthma _____ Diabetes _____ Stroke _____
Goiter _____ Bleeding disorders _____ Breast Cancer _____ High blood pressure _____
Other Cancer _____

SERIOUS ILLNESSES OR INJURIES: *(Please give year of occurrence.)*

Illness/injury _____ Year _____

Illness/injury _____ Year _____

OPERATIONS:

Operations _____ Year _____

Operations _____ Year _____

WOMEN ONLY

Is there a chance you may be pregnant? Y N Regular menses? Y N Date of last menstrual Period _____

Any complications with pregnancies? _____
How many pregnancies? _____ How many children? _____ Did you breastfeed? Y N How many? _____
Date of last mammogram _____ □Normal □Abnormal

Specify abnormality _____

Breast cancer: L R Date _____ Mastectomy _____ Date: _____

Breast biopsy: L R Date _____ Oncologist: _____

Surgeon for breast biopsy _____ Telephone Number: *(If Known)* _____

Address: *(If Known)* _____

CONSENT FOR TREATMENT: I hereby consent to treatment and/or services by providers at Dermatology Associates of San Antonio to include examination, treatment, prescribing medication, and skin preparations.
RELEASE OF INFORMATION: I hereby authorize the release of any and all medical information to my insurance carrier(s) or their representative(s), for purposes necessary in the adjudication or processing of any and all insurance claims(s) filed on my behalf and for which I am financially responsible. I also authorize the release of any or all medical information to my primary care or referring physician, to consultant if needed, and as necessary to process prescriptions.
ASSIGNMENT OF BENEFITS: I further authorize all insurance benefits be paid to the provider rendering services on behalf of Dermatology Associates of San Antonio, I understand for payment for professional services, including co-payments and deductibles and fees for cosmetic services, are due at time services are rendered. I acknowledge if my managed care plan declines to cover a service for any reason, it becomes the sole obligation of the patient, parents, or guardian to pay in full.
PRIVACY PRACTICES (HIPAA): I acknowledge I have received a copy of Dermatology Associates of San Antonio Notice of Privacy Practices. This document is posted in our front lobby and is available at the front desk.
EMAIL POLICY: Dermatology Associates of San Antonio subscribes itself to the principle of email privacy. Any information submitted will be used only for requested information and internal purposes and will not be sold or revealed to any third parties.

I have read, understood and agreed to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Signature: _____ **Date:** _____