PERSONAL HISTORY QUESTIONNAIRE

This information is confidential and will not be released

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.)*

How did you hear about us: (Website, Dr. Referral, Family/Friend etc.) ______________

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 use tobacco? Y N Never How much per day? ______________

Do you regularly consume alcohol? 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: ______________________

Pharmacy Name: ______________ **Pharmacy Number:** ______________

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 RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBER OR PERSONAL REPRESENTATIVE:

□ YES □ NO □ PRESCRIPTIONS □ FINANCIAL □ PATHOLOGY/LAB RESULTS WITH THE FOLLOWING PERSON(S)

I UNDERSTAND THIS AUTHORIZATION MAY INCLUDE INFORMATION RELATED TO HIV, AIDS, PSYCHIATRIC CARE, TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE, OR GENETIC TESTING

AUTHORIZED PERSON(S) / RELATIONSHIP: ____

EMERGENY CONTACT: ______________________ RELATIONSHIP: ______________________ PHONE: __________________________

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, understand, and agree to the above. The information which I have provided is true and complete to the best of my knowledge.

Signature: ____ **Date:** _________________________