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

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:_____
_____
Number of alcoholic drinks per day. (circle one)
None Less than 1 per day 1-2 per day 3 or more per day
Do you smoke? (circle one) **Current (Packs per day)____** **Former** **Never**

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
Alergy 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

Acknowlegement 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_____