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WELCOME PACKET / HEALTH HISTORY

We are pleased that you have chosen our practice for your dermatologic needs. Our goal is to provide the highest quality of care for your general, medical, and cosmetic dermatology needs.

Please bring this completed Packet to your scheduled appointment. You are also welcome to forward these completed forms to our office via mail, fax or personal delivery should that be more convenient for you.

**If your insurance requires a referral it is your responsibility to obtain that referral from your primary care physician and confirm that our office has received your referral prior to your scheduled appointment.

Many insurance plans require that we obtain authorization for procedures performed in our office including biopsies, cryotherapy, and injections. We will do our best to minimize additional trips to our office, but you may be required to return to the office to have a procedure performed after your initial consultation. Please note that all appointments are scheduled for 15 minutes. If your condition warrants additional time spent, you may be scheduled to return to the office.

For your appointment please be prepared with the following:

1. A list of your current Medications including over the counter medications
2. Your Insurance Card
3. Your Photo Identification
4. Your Recent Lab or Pathology Results
5. Copay is due upon checkout

Patient Name: _____ Date of Birth: _____Today's Date:_____
Parent/Guardian _____(if 18 y.o. or under) Height _____ Weight_____
Patient Home#_____ Patient Cell# _____
LAST 4 Social security# _____
Preferred Pharmacy: _____ City: _____
Family Doctor: _____

MEDICAL HISTORY: Please check all that apply – Past or Present

- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding, Excessive
- ☐ Blood Clots
- ☐ Bruising easily
- ☐ Colon/Intestinal Disorder:_____
- ☐ Diabetes: Type I__ II__
- ☐ Headaches (chronic)
- ☐ Heart Problems:_____
- ☐ Hepatitis
- ☐ Herpes Simplex (cold sores)
- ☐ Herpes Zoster (Shingles)
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Infections (chronic)
- ☐ Kidney Disease:_____
- ☐ Liver Disease:_____
- ☐ Lung Disease:_____
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker/Defibrillator
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Varicose Veins
- ☐ OTHER (Please list):

_____

** Females: ☐ Chronic vaginal infections ☐ Taking oral contraceptives
☐ Currently pregnant ☐ Possibly pregnant ☐ Breast Feeding
☐ Date of last menstrual period: _____ ☐ Hysterectomy (date): _____

SURGICAL HISTORY:

1._____

2._____

SKIN CANCER/OTHER SKIN HISTORY:

☐ None ☐ Malignant Melanoma ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma

☐ Family History of Malignant Melanoma (relationship) _____

☐ Acne ☐ Eczema ☐ Loss of Skin Pigment/Vitiligo ☐ Psoriasis ☐ Scarring/Keloids ☐ Ulcers, Skin

☐ Warts ☐ Wound healing difficulty

☐ Other Cancer(s) (Please List Types): _____

HISTORY OF RADIATION TREATMENT: ☐ No ☐ Yes

If Skin Cancer: When treated and at what Facility: _____

Do you use SUNSCREEN? ☐ Yes ☐ No If so SPF?: _____ Do you use a Tanning Bed?: ☐ Yes ☐ No

CURRENT MEDICATIONS: Name, Strength and Dose – OR bring a list so that we may make a copy for your chart

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

DO YOU REQUIRE PRE-MEDICATION* PRIOR TO SURGERY? ☐ No ☐ Yes

* Do you take Antibiotics prior to Dental Procedures, Surgeries or do you have an Artificial Heart Valve or Artificial Joint?

(If yes, Describe) _____

DRUG ALLERGIES: Please check and name the specific drug and if known list the type of reaction you experienced:

☐ No Known Drug Allergies

☐ Anesthetics _____ ☐ Aspirin _____ ☐ Lidocaine _____

☐ Penicillin _____ ☐ Sulfa _____ ☐ Tetracycline _____

☐ Other drugs and type of reaction _____

ARE YOU ALLERGIC TO LATEX: ☐ No ☐ Yes Include Reaction _____

NON-DRUG ALLERGIES (INCLUDE SOURCE AND REACTION) _____

_____

SOCIAL HISTORY:

Do you use TOBACCO? ☐ Yes ☐ Never ☐ Quit How much per day? _____ How many years? ____

Do you drink ALCOHOL? ☐ Yes ☐ Never ☐ Quit

If yes, how much? _____ How often? _____

Do you use RECREATIONAL DRUGS? ☐ Yes ☐ Never ☐ Quit

If yes, how much? _____ How many years? ___

OCCUPATION: _____ ☐ Working ☐ Retired ☐ Disabled

Children: ☐ Yes ☐ No If yes, how many? _____

FAMILY HISTORY: (Please check all that apply and list family member)

☐ Allergies _____ ☐ Arthritis _____ ☐ Psoriasis _____
☐ Cancer _____ ☐ Diabetes _____ ☐ Eczema _____
☐ Hay fever _____ ☐ Lupus _____ ☐ Tuberculosis _____
☐ Asthma _____
☐ Skin Cancer _____ ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Malignant Melanoma

OTHER PERTINENT HISTORY:

1. _____
2. _____
3. _____

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY and USE OF MEDICAL PHOTOGRAPHY

Initial beside the line that indicates your preference.

Medical photography may include still photography as well as video. Photographs will only be used to aid in diagnosis and treatment plans, health care administration, and other uses specifically allowed by law. These photos will be kept on the patient's record, and patient has access to photos upon written request. Images will not be printed, published, or otherwise circulated without further consent. Images may be used in conjunction with transition of care documents if patient requires treatment with an outside office and is referred to another provider.

_____ I DO authorize photographs to be taken during my visit

_____ I DO NOT authorize photographs to be taken during my visit

Medical photographs within the patient's chart may be used for purposes of medical education and teaching, for publication in medical textbooks and journals, and for marketing and advertising in print or on the BHS Dermatology Website. These photographs will not be sold at any time to a third party. Patient names will not be identified and every effort will be made to limit the ability of others to identify the patient in the photograph. By giving consent to Dr. Chad S. Hendrickson and all representatives and staff of BHS Dermatology to use my medical photographs, the patient understand that he/she will not receive payment from any party at any time. Patient also hereby releases and discharges Dr. Chad S. Hendrickson, BHS Dermatology Associates, and their employees, trustees and offices from any claims, demands, or legal actions for use of these images from my medical record.

_____ I DO authorize the use of my photographs from my medical record for purposes of medical education and teaching.

_____ I DO NOT authorize the use of my photographs from my medical record for purposes of medical education and teaching.

Patient Signature: _____ **Date:** _____ **Time:** _____

or

Patient Representative: _____ **Date:** _____ **Time:** _____