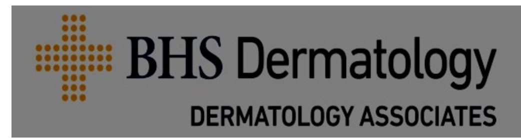

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WELCOME PACKET / HEALTH HISTORY

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

Email:____

Name: ____ ☐ Male ☐ Female

Social Security Number: ________________________ Date of Birth: __________________

Address: ________________________ City: _________ State: ______ Zip Code: _________

Telephone: __________________________ Cell Phone: ______________________________

Emergency Contact: ________________________ Relationship to Patient: __________________

Address: ______________________________City: ___________ State: ______ Zip: ________

Home Phone: __________________________ Cell Phone: ______________________________

Primary Care Physician: ______________________________ City ________________________

Preferred Pharmacy Name/Location: __________________________________

Patient Name: ___________________________ Date of Birth: __________Today's Date:________

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

- ☐ Acne
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding, Excessive
- ☐ Blood Clots
- ☐ Bruising easily
- ☐ Colon/Intestinal Disorder
- ☐ Diabetes: Type I__ II__
- ☐ Eczema
- ☐ Seasonal Allergies
- ☐ Headaches (chronic)
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Herpes Simplex (cold sores)
- ☐ Herpes Zoster (Shingles)
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Infections (chronic)
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Loss of Skin Pigment
- ☐ Lung Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker/Defibrillator
- ☐ Psoriasis
- ☐ Rheumatic Fever
- ☐ Scarring/Keloids
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers, Skin
- ☐ Varicose Veins
- ☐ Vitiligo
- ☐ Warts
- ☐ Wound healing difficulty
- ☐ 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 HISTORY: ☐None ☐Malignant Melanoma ☐Basal Cell Carcinoma ☐Squamous Cell Carcinoma
☐ 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 drink ALCOHOL? ☐ **Yes** ☐ **Never** ☐ **Quit**

If yes, how much? ________ How often? ____________

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

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

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

OCCUPATION: ____ ☐ **Working** ☐ **Retired** ☐ **Disabled**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

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 ______________ ☐ 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: __________