

Medical History

Name: _____ Date: _____

Reason for Visit: _____

Are you allergic to any medications? Yes No

Do you have or have you had any of the following:

<p><u>GENERAL</u></p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Hair loss <input type="checkbox"/> Headache <input type="checkbox"/> Weight change	<input type="checkbox"/> Keloid/scarring problems <input type="checkbox"/> Melanoma <input type="checkbox"/> Mole change <input type="checkbox"/> Psoriasis <input type="checkbox"/> Sore that won't heal	<p><u>CARDIOVASCULAR</u></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High Blood pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Swelling of ankles	<p>MEN only</p> <input type="checkbox"/> Sore on genital <input type="checkbox"/> Other _____ _____
<p><u>SKIN</u></p> <input type="checkbox"/> Acne <input type="checkbox"/> Actinic Keratosis <input type="checkbox"/> Atopic Dermatitis <input type="checkbox"/> Bruise easily <input type="checkbox"/> Carcinoma (basal/squamous cell) <input type="checkbox"/> Hives <input type="checkbox"/> Itching/Rash	<p><u>MUSCLE/JOINT/BONE PAIN</u></p> <input type="checkbox"/> Hands <input type="checkbox"/> Knees <input type="checkbox"/> Artificial joint/metal implants	<p><u>GASTROINTESTINAL</u></p> <input type="checkbox"/> Appetite loss <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	<p>WOMEN only</p> <input type="checkbox"/> Irregular menstrual cycles <input type="checkbox"/> Menopause <input type="checkbox"/> Nursing <input type="checkbox"/> Pregnant <input type="checkbox"/> Other _____ _____ Date of last period _____
<p><u>CONDITIONS</u></p> <input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Asthma <input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> Blood/bleeding disorder	<input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Emphysema <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gout <input type="checkbox"/> Hay fever	<input type="checkbox"/> Heartburn/Reflux/ Ulcers/ Gastritis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Herpes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Lung Disease	<input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Prostate problem <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Other _____ _____

Have you had any of the following Cosmetic treatments? *(If yes, please check)*

INJECTABLES:

- Botox
- Restylane/Perlane
- Juvederm
- Sclerotherapy
- Other _____

LASER TREATMENTS

- Fraxel
- ILP (photo facial)
- Laser Hair Removal
- Other _____

ESTHETICIAN SERVICES:

- Microdermabrasion
- Chemical Peel
- Medical Acne Facial
- Other _____

Are you interested in learning more about any of the above treatments? Yes No

(If yes, please list)

1.	3.	5.
2.	4.	6.

Jones Dermatology

Patient Information

Patient's Last Name:		First Name:		Middle Initial:	
Mailing Address:		City:	State:	Zip:	
Street Address, City, State, Zip (if different than mailing):					
Email Address:					
Home Phone: ()		Cell Phone: ()		Work Phone: ()	
Primary Care Physician:			Referring Provider:		
How Did You Hear About Our Office? <input type="checkbox"/> Internet: <input type="checkbox"/> Physician (same as above) <input type="checkbox"/> Friend/Relative: <input type="checkbox"/> Other:					

RESPONSIBLE PARTY (If patient is a child)

Last Name:		First Name:			
Mailing Address:		City:	State:	Zip:	
DOB:	Relationship to Patient:	Best # to reach by phone: ()			
Social Security #:					

PRIMARY INSURANCE (please give your insurance card to the receptionist)

<input type="checkbox"/> Self-Pay <input type="checkbox"/> Patient is the Insured Subscriber	Policy Subscriber's Name (if not patient):	Policy Subscribers DOB:
Name of Primary Insurance:	Policy Subscriber's Social Security #:	
Patient's Relation to Card Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child		
If Medicare Patient, are you currently employed: <input type="checkbox"/> Y <input type="checkbox"/> N		

SECONDARY INSURANCE (please give your insurance card to the receptionist)

<input type="checkbox"/> Self-Pay <input type="checkbox"/> Patient is the Insured Subscriber	Policy Subscriber's Name (if not patient):	Policy Subscribers DOB:
Policy Subscriber's Social Security:		

IN CASE OF EMERGENCY

Name of Emergency Contact Person:	Relation to Patient:	Home Phone: ()	Cell Phone: ()
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Co-pays and deductibles will be collected at the time of service. Payment for cosmetic procedures and products are due at the time of service. I authorize Dr. Jones and Dr. Matherne to evaluate and treat my medical condition. I authorize the release of medical information as needed to my primary care physician, referring physician, consultants and insurance carrier to process insurance claims, applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient/Guardian signature:	Date:
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