hopkins DERMATOLOGY

**Dermatology Medical History**

Patient: _____ Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list: _____

Have you ever had dental anesthesia (Novocain) or local anesthesia (Lidocaine)? ☐ YES ☐ NO

Any bad reaction? ☐ YES ☐ NO Explain, if yes: _____

List all medications you are currently taking **(including prescriptions, over-the-counter meds, vitamins, and herbals):**

_____

_____

Primary Physician: _____ Referring Physician: _____

General Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

**Do you currently have, or have you ever had any of the following diseases or conditions: (Please check YES or NO)**

| **Lungs:** | **YES** | **NO** |
|---|---|---|
| Bronchitis | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Chronic Cough | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Shortness of Breath | ☐ | ☐ |

| **Cardiovascular:** | **YES** | **NO** |
|---|---|---|
| High Blood Pressure | ☐ | ☐ |
| Heart Attack | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ |
| Irregular Heartbeat | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Varicose Veins | ☐ | ☐ |
| Blood Clots | ☐ | ☐ |
| Bleeding Disorders | ☐ | ☐ |
| Prolonged Bleeding | ☐ | ☐ |

| **Skin:** | **YES** | **NO** |
|---|---|---|
| History of skin cancer | ☐ | ☐ |
| If yes, type: _____ | | |
| Family history skin cancer | ☐ | ☐ |
| If yes, type: _____ | | |
| History of specific skin diseases | ☐ | ☐ |
| Problems with healing | ☐ | ☐ |
| Excessive scarring/Keloids | ☐ | ☐ |
| Easy bleeding | ☐ | ☐ |
| Skin rashes | ☐ | ☐ |
| Reaction to Medications | ☐ | ☐ |
| Reaction to Food | ☐ | ☐ |
| Reaction to Environment | ☐ | ☐ |
| Sensitivity to Sunlight | ☐ | ☐ |

| **Other Systemic:** | **YES** | **NO** |
|---|---|---|
| Diabetes | ☐ | ☐ |
| Lupus | ☐ | ☐ |
| Thyroid Disease | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ |
| Bladder Infections | ☐ | ☐ |
| Connective Tissue Gastrointestinal | ☐ | ☐ |
| Stomach Disorder | ☐ | ☐ |
| Stomach Ulcers | ☐ | ☐ |
| Nausea, vomiting, diarrhea when taking antibiotics | ☐ | ☐ |
| Yeast infection when taking antibiotics | ☐ | ☐ |
| Arthritis/Joint Deformity | ☐ | ☐ |
| Convulsions | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| Fainting | ☐ | ☐ |
| Anxiety/Depression | ☐ | ☐ |
| Mental Disorder | ☐ | ☐ |
| Glasses or Contacts | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| Liver Disease | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Type: _____ | | |

| **Social History:** | **YES** | **NO** |
|---|---|---|
| Do you smoke? | ☐ | ☐ |
| Do you drink alcohol? | ☐ | ☐ |
| If yes, _____ per day | | |
| Do you use IV drugs? | ☐ | ☐ |
| If yes, what? _____ | | |
| How often? _____ | | |

| **Infectious Diseases:** | **YES** | **NO** |
|---|---|---|
| HIV/AIDS | ☐ | ☐ |
| Hepatitis A, B, or C | ☐ | ☐ |
| Syphilis/other sexually transmitted diseases | ☐ | ☐ |

| **Females:** | **YES** | **NO** |
|---|---|---|
| Are you pregnant? | ☐ | ☐ |
| Could you be pregnant? | ☐ | ☐ |

Date of last menstrual cycle: ___/____/_____

Type of Birth Control: _____

Previous Pregnancies: _____

_____

_____

_____

**Past Medical History: _____**

_____

_____

**Past Surgical History: _____**

_____

_____

_____

I hereby declare that I have honestly and completely answered the above questions to the best of my knowledge. I understand that it is my obligation and responsibility to notify Dr. Hopkins of any changes in my medical condition or medications during the course of my medical treatment or at follow up visits.

_____ _____ _____ _____

Reviewed By Date **Patient Signature** **Date Signed**

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# AUTHORIZED CONSENT

**I accept full responsibility for services rendered and understand that payment in full is due at the time of service.**

**Please present insurance cards and photo ID to the receptionist so copies may be made.**

**I authorize and request that all insurance payments be made direction to Dr. Hopkins, should she elect to bill my insurance company and accept such payments.**

**I hereby authorize and consent Dr. Hopkins and Staff to:**

1. **Evaluate and treat my medical conditions.**
2. **Call me at home or my place of employment with regard to appointment reminders, lab results, or any other information pertaining to my care.**
3. **Leave a message on my answering machine with appointment reminders, or regarding lab results. (Results will not be left in the form of a message).**
4. **Send information to me in the mail, via text or email regarding appointments or patient education/information**
5. **Release medical records to my referring or primary physician, and to my insurance company, if applicable.**
6. **If you have questions concerning the cost of a planned procedure, it is your responsibility to discuss this with the office manager or a staff member BEFORE the procedure is done. Payment of charges is required at the time of the office visit. WE ARE NOT CONTRACTED WITH ANY INSURANCE EXCEPT MEDICARE, UNITED HEALTHCARE, AND BLUE CROSS BLUE SHIELD. We will give you the proper forms to be submitted to your insurance company for reimbursement. Cosmetic procedures are not likely to be reimbursed by insurance and other fees may be reimbursed at reduced insurance fees; and therefore, all of your expense may not be covered.**

**At my request, discuss my medical condition or appointment with another member of my household/family?**

☐ **Yes** ☐ **No**

**If yes, whom: _____ Relationship: _____**

**Telephone #: _____**

_____
**Patient Signature**

**It is my responsibility to notify this office of any change in the above information. I understand that by signing this form I have read and understand my responsibility.**

_____ _____
**Signature** **Date**

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**M. JANINE OSWALT HOPKINS, M.D.**

**Acknowledgement of Receipt of Notice of Health Information Privacy Practices**

**I, (Printed Patient Name)_____,**
**acknowledge receipt of the Notice of Health Information Privacy Practices.**

**By: (Patient Signature)_____**

**This_____day of_____ 20____.**

*2509 Broadmoor Blvd., Suite A, Monroe, LA 71201 Phone: 318-325-0600 Fax: 318-325-0890 www.hopkinsdermatology.com*