DERMATOLOGY MEDICAL HISTORY

Patient Name:_____DOB: _____DATE: _____/_____/_____

Referring Provider: _____ Phone # _____

Primary Care Provider: _____ Phone #_____

Name of Pharmacy: _____ Phone #_____

Reason for your visit: _____

Are you allergic to any medications? (circle one, if YES please list) YES NO _____

Have you ever had a bad reaction to dental anesthesia? (circle one) YES NO Never had dental anesthesia

List all Medications you are currently taking (including prescription, over the counter, vitamins, and herbals)

1: _____ 2: _____ 3._____

4: _____ 5:_____ 6:_____

Do you have now or have you ever had diseases or conditions of: (please check yes or no)

Lungs:

Bronchitis	Yes___ No___
Emphysema/COPD	Yes___ No___
Asthma	Yes___ No___

Heart:

High Blood Pressure	Yes___ No___
Heart Attack	Yes___ No___
Cholesterol Issues	Yes___ No___
Heart Murmur	Yes___ No___
Irregular Heartbeat	Yes___ No___
Blood Clots	Yes___ No___
Pacemaker	Yes___ No___
Coronary Artery Disease	Yes___ No___

Endocrine:

Diabetes	Yes___ No___
Thyroid (Hyper or Hypo)	Yes___ No___
Kidney	Yes___ No___
Dialysis	Yes___ No___

Cancer:

Type of Cancer: _____

Infectious Disease:

HIV/AIDS	Yes___No___
HEP B	Yes___ No___
HEP C	Yes___ No___

List Major Surgeries and the year they were performed:

_____

GI:

Reflux	Yes___ No___
Stomach Problems	Yes__ No___
Irritable Bowel	Yes___ No___

GU:

Bladder Problems	Yes___ No___
Yeast Infections w/Antibiotics	Yes___ No___

Rheumatologic:

Arthritis	Yes___ No___
Artificial Joint	Yes___ No___

Neurologic:

Memory Problems	Yes___ No___
Hearing Loss	Yes___ No___
Seizures/Fainting	Yes___ No___
Headaches	Yes___ No___
Stroke	Yes___ No___

Psychological:

Depression	Yes___ No___
Anxiety	Yes___ No___

Other:

Enlarged Lymph Nodes	Yes___ No___
Excessive Weight Loss	Yes___ No___
Flu Vaccination Yearly	Yes___ No___

65 years & Older:

Pneumonia Vaccination	Yes___ No___

Skin:

History of Skin Cancer	Yes___ No___ if yes type:_____
Family History of Skin Cancer	Yes___ No___ if yes type:_____
History of a Skin Disease	Yes___ No___ if yes type:_____
Problems with Healing	Yes___ No___
Do you bleed easily?	Yes___ No___
Develop rashes to bandages or Neosporin?	Yes___ No___

Women: Are you Pregnant? Yes___No___ **Are you Breastfeeding?** Yes___ No___

Smoking Status: *(circle one please)* Never Current Former

What is your occupation? _____ Hobbies? _____

Patient Signature:_____DATE: _____/_____/_____

Pediatric Patients Only: Height_____ Weight_____

FOREFRONT DERMATOLOGY®
AND AFFILIATED PRACTICES

Minor Patient Consent Form

Patient's Name: _____ **Patient's Date of Birth** _____/___/_____

All minors must be accompanied by a parent or a legal guardian for their first visit with our practice. Unfortunately, due to informed consent and contracting laws, we cannot treat your child for a new condition until we have informed you of the specific diagnosis and suggested treatment they require and then receive your consent and approval. **If a parent or legal guardian is not present at the time of a minor child's appointment, the child can only be evaluated, and only if a parent or legal guardian consents to the evaluation in advance by completing Section 1 below. Unfortunately, no treatment for a newly discovered condition can occur until authorized by a parent or legal guardian after receiving the appropriate information.**

1. **Evaluation authorization** by parent/legal guardian only: ***(Check one box only)***

   ☐ I will be attending all appointments with my minor child and do not want my minor child evaluated unless I am present.

   ☐ I will not be attending follow up appointment(s) with my minor child and give consent and approval for any evaluation deemed appropriate by the provider. I understand that unless I am immediately available to authorize any additional treatments, my minor child will need to come back for additional treatment after I provide the necessary authorization and consent.

2. **Treatment authorization** by parent/legal guardian only: ***(Check one box only)***

   ☐ I will be attending all appointments with my minor child and will be present to give consent if a procedure is recommended. You may not treat my minor child without my authorization and approval at the time of treatment.

   ☐ I will not be attending follow up appointment(s) with my minor child and give consent and approval for ongoing care of any previously diagnosed condition for which I have already provided informed consent.

3. **Insurance information:**

   If you ***are*** attending the appointment with your minor child, please present the insurance card(s) and photo identification to the receptionist.

   If you ***are not*** attending the appointment(s) with your minor child, please have your minor child bring the card(s) to the appointment or attach a copy of the card(s) to this form. Also send along any co-payments.

   Name of parent/guardian: _____ **Parent/Guardian's date of birth:** _____/_____/_____

   Parent/Guardian's relationship to patient: _____

4. **Payment Policy:**

   The parent or legal guardian who signs this form will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees. We will only respond to a court order that directs Forefront Dermatology to act in a certain way.

   Guardian Signature: _____ **Today's Date:** _____/_____/_____

5. **Parent/Guardian Contact information:**

   Father/Guardian (please print): First name_____ Last name _____

   Phone (8 am-5 pm):_____-_____-_____ home / mobile / work (circle one)

   Secondary # (8 am-5 pm):_____-_____-_____home / mobile / work (circle one)

   Mother/Guardian (please print): First name_____ Last name _____

   Phone (8 am-5 pm):_____-_____-_____ home / mobile / work (circle one)

   Secondary # (8 am-5 pm):_____-_____-_____home / mobile / work (circle one)