PATIENT HISTORY

This is confidential medical information.
Accurate and complete medical information is needed to help us provide optimal care.

Patient's Name: _____ **Todays Date:** _____

What is the reason for today's appointment?

_____

MEDICATIONS

List names, dosages, and frequency of any current medications **OR** provide a list to the front desk

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICAL HISTORY

Have you ever had skin cancer?

☐ Yes, on record at JCD ☐ No ☐ Unsure

☐ Yes, outside records: _____

List the practitioner that treated it, date it was treated, type of skin cancer, and location on body

Have you previously been diagnosed with any chronic skin conditions?

☐ Psoriasis ☐ Eczema ☐ Other: _____

Have you ever had the following?

☐ AIDS/HIV
☐ Allergies
☐ Arthritis
☐ Asthma
☐ Bleeding disorder or on a blood thinner
☐ Cancer, type: _____
☐ Defibrillator
☐ Depression
☐ Diabetes
☐ Genetic disease, type: _____
☐ GI/bowel disease, type: _____
☐ Glaucoma
☐ Heart attack/disease
☐ Hepatitis, type: _____
☐ High cholesterol / triglycerides
☐ Hypertension
☐ Joint replacement
☐ Lupus
☐ Multiple sclerosis
☐ Organ transplant, type: _____
☐ Pacemaker
☐ Psychiatric disorder
☐ Radiation, explain: _____
☐ Seizures
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis

Other chronic or current medical condition(s) not listed _____

_____

PLEASE COMPLETE THE FRONT AND BACK OF THIS FORM IN ITS ENTIRETY

PATIENT HISTORY

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Accurate and complete medical information is needed to help us provide optimal care.

Patient's Name: _____

ALLERGIES TO MEDICATIONS

List the medication name and type of reaction

_____ _____

_____ _____

_____ _____

HOSPITALIZATIONS / SURGERIES

List any hospitalizations or surgeries within the last 12 months

_____

_____

_____

OCCUPATION

If retired, please list your former occupation

_____

SUNSCREEN USE

How often do you use sunscreen? ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

Other sun safe habits? ☐ Hat ☐ UPF rated clothing ☐ Umbrella ☐ Other: _____

WOMEN ONLY

Are you currently pregnant? ☐ Yes Due: _____ ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Are you planning pregnancy? ☐ Yes ☐ No

FAMILY HISTORY

	Mother	Father	Siblings	Child
Skin cancer (non-melanoma type)				
Melanoma				
Asthma				
Allergies				
Eczema				
Lupus				
Multiple Sclerosis				

please notify your clinician or practitioner of any current changes in your health

PLEASE COMPLETE THE FRONT AND BACK OF THIS FORM IN ITS ENTIRETY

JOHNSON COUNTY DERMATOLOGY

COMMUNICATION PREFERENCES

In certain circumstances, we may need to contact you regarding your dermatology care. (e.g. lab or pathology results, prescription medications, upcoming appointments, account balances or credits.)

Messages left on a number designated as home will be brief in nature.

Home Voicemail ◯ **Y** ◯ **N**

Cell Voicemail ◯ **Y** ◯ **N** Text Message ◯ **Y** ◯ **N**

3rd PARTY RELEASE OF INFORMATION

You may discuss my medical information, care and/or billing account information with the following.

***If no one is listed, we will be unable to speak with anyone other than the patient or guardian of a minor patient.**

Name_____ Relationship _____

Name_____ Relationship _____

If you need to change any of the above preferences, you must request to do so in writing.

HIPAA PRIVACY NOTIFICATION

I have read and/or been offered a copy of the Notice of Privacy Practices for Johnson County Dermatology, PA.

I understand that this acknowledgement will expire 1 year from the date it is signed.

I understand that I may request a copy of the Privacy Notification in the future by contacting Johnson County Dermatology, PA at (913) 764-1125 or by writing to 153 W 151st Street, Suite 100, Olathe, KS 66061.

Signature _____ **Date** _____
(If patient is under the age of 18, parent or guardian signature is required)