Patient Information Sheet

PATIENT NAME_____

SS# _____ Date of Birth _____ M__ F__

Home Phone _____ Cell Phone _____

Mailing Address _____

City/State/Zip_____

Home Address_____

City/State/Zip_____

POLICY HOLDER NAME _____

SS# _____ Date of Birth_____ M__ F__

Place of Employment _____

Employment Phone No. _____

SPOUSE/PARENT NAME _____

SS# _____ Date of Birth_____ M__ F__

Place of Employment _____

Employment Phone No. _____

EMERGENCY CONTACT _____

Relationship _____ Phone No. _____

Patient Name: _____ Day time phone #: _____
Chart #: _____ Evening phone #: _____
Date: _____ Emergency phone #: _____

Welcome to our practice. As a new patient, we will discuss your health in detail. To help us in this discussion, please complete the front and back sides of this questionnaire

Primary Care Doctor: _____ Referring Doctor: _____
Reason for visit: _____
MEDICAL HISTORY:

Current Medications (prescription or over-the-counter):

_____
_____
_____
_____

Allergies: _____

Previous Major Illnesses/Injuries/Surgeries (Please include dates):

_____
_____
_____

Past Medical History:

Diabetes	Yes	No
Hypertension	Yes	No
Skin cancer	Yes	No
Other cancer	Yes	No
Heart trouble	Yes	No
Arthritis/gout	Yes	No
Difficulty healing	Yes	No
Bleeding tendency	Yes	No
Venereal disease	Yes	No
Hereditary disease	Yes	No
Asthma	Yes	No
Eczema	Yes	No
Hives	Yes	No
Psoriasis	Yes	No
Melanoma	Yes	No
Other skin prob.	Yes	No

_____ (if answer is yes, explain)

Social History:

Marital status: _____
Use of alcohol: Never Rarely
Moderate Daily
(circle answer above)
Use of tobacco: Never
Previously, but quit
Currently packs/day _____
Use of drugs: Never
Type/frequency: _____
Hobbies: _____
_____
Occupation: _____

Family Medical History: (If you have no information, please also state).

Have any of your family members ever had any of the following conditions: (Please circle if yes) Asthma Eczema Psoriasis Hives Skin Cancer Melanoma Other skin problems

	Age	Diseases (If healthy, leave blank)	If Deceased, cause of death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
Children	____	_____	_____
Other	____	_____	_____

Review of Systems: Please indicate any personal history of currently active problems.

CONSTITUTIONAL SYMPTOMS

Good general health ..... YES NO
Recent weight change ..... YES NO
Fever/Nightsweats ..... YES NO
Excess Fatigue ..... YES NO

EYES

Eye disease or injury..... YES NO
Glaucoma/cataracts ..... YES NO

EARS/NOSE/THROAT

Problems with hearing ..... YES NO
Sore throat ..... YES NO
Voice change ..... YES NO
Swollen glands..... YES NO
Nose bleeds ..... YES NO
Mouth sores ..... YES NO

CARDIOVASCULAR

Heart trouble (murmur, rheumatic fever,
Valve disease, pacemaker..... YES NO
Heart attack..... YES NO
Artificial valve ..... YES NO
Chest pain/angina ..... YES NO
Palpitation ..... YES NO
Shortness of breath..... YES NO
Swelling of feet/ankles ..... YES NO
Poor circulation ..... YES NO
High blood pressure..... YES NO

RESPIRATORY

Lung disease..... YES NO
Difficulty breathing..... YES NO
Asthma/wheezing..... YES NO

GASTROINTESTINAL

Intestinal/stomach disease..... YES NO
Liver or gallbladder disease ..... YES NO
Abdominal pain ..... YES NO
Peptic ulcer (stomach or duodenal) .. YES NO

GENITOURINARY

Bladder problems..... YES NO
Kidney disease..... YES NO
Problems with urination..... YES NO
Kidney stones ..... YES NO
Sexual difficulty..... YES NO
Male-testicle pain/lumps ..... YES NO
Prostate problems..... YES NO
Female-irregular periods..... YES NO
Vaginal yeast infection ..... YES NO
Estrogen replacement..... YES NO
Hysterectomy..... YES NO
Pregnant or nursing ..... YES NO
Planning a pregnancy..... YES NO
Current form of birth control _____
Last menstrual period _____
Age of onset of menopause _____

MUSCULOSKELETAL

Joint pain..... YES NO
Joint stiffness..... YES NO
Weakness of muscles ..... YES NO
Artificial joints ..... YES NO

INTEGUMENTARY (skin/breasts)

Problems with scarring/keloids..... YES NO
History of radiation treatment..... YES NO
Varicose veins ..... YES NO
Breast pain ..... YES NO
Breast lump ..... YES NO
Breast discharge ..... YES NO

NEUROLOGIC

Frequent/recurring headaches ... YES NO
Light headed or dizzy..... YES NO
Convulsions/seizures ..... YES NO
Stroke..... YES NO

PSYCHIATRIC

Nervousness ..... YES NO
Depression ..... YES NO
Other ..... YES NO

ENDOCRINE

Glandular or hormone problem .. YES NO
Thyroid disease..... YES NO
Diabetes (insulin or noninsulin) .. YES NO

HEMATOLOGIC/LYMPHATIC

Taking blood thinners now..... YES NO
Slow to heal after cuts..... YES NO
Bleeding or bruising tendency.... YES NO
Anemia ..... YES NO
Phlebitis..... YES NO
Past transfusions..... YES NO
Blood or lymph gland disorder ... YES NO
Cancer of leukemia ..... YES NO

ALLERGY/IMMUNOLOGY/INFECTIOUS DISEASE

History of venereal disease (STD) YES NO
History of HIV infection/AIDS ..... YES NO
History of hepatitis..... YES NO
History of frequent infections..... YES NO
If Yes, where? _____
History of reaction to:
Local anesthesia ..... YES NO
Latex/rubber..... YES NO
Food allergies: _____
Environmental allergies: _____
Any other health problems: _____
_____

Total Body Skin Exam: _____

Reviewed by: _____

PRACTICE ACKNOWLEDGEMENTS

SHONDRA L. SMITH, M.D.
3635 Nelson Road
Lake Charles, LA 70605
Telephone: (337) 477-0011

Patient Name: _____ Date of Birth: _____

HIPPA ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

Signature: _____ Date: _____

PLEASE KEEP ATTACHMENT (Notice of Privacy Practices)

NOTICE OF FINANCIAL RESPONSIBILITY

I understand it is my responsibility to contact my insurance company to establish if Dr. Smith is an approved provider of Dermatology services and to obtain any referrals that my insurance requires **prior** to my appointment. Dr. Smith's office will file my medical claim as a courtesy. I understand if for **any** reason my claim is denied, **I will be responsible for any and all non-covered services.**

I also understand that balances over 90 days past due, with no attempt to pay, will be turned over to a collection agency.

_____
Printed name of person with financial responsibility

_____ _____
Signature of person with financial responsibility Date