Welcome to Dermatology and Advanced Aesthetics. 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.

Patient Name: _____ Daytime phone #: _____
Date: _____ Evening phone #: _____
Email: _____
Primary care doctor: _____ Referring Doctor: _____
Reason for visit: _____

CURRENT MEDICATIONS:

_____
_____
_____
_____

ALLERGIES: _____
PREVIOUS MAJOR ILLNESSES/INJURIES/SURGERIES:

_____
_____
_____

PAST MEDICAL HISTORY:

DIABETES	YES	NO	ECZEMA	YES	NO
HYPERTENSION	YES	NO	HIVES	YES	NO
HEART TROUBLE	YES	NO	PSORIASIS	YES	NO
ARTHRITIS/GOUT	YES	NO	MELANOMA	YES	NO
DIFFICULTY HEALING	YES	NO	SKIN CANCER	YES	NO
BLEEDING TENDENCY	YES	NO	OTHER CANCER	YES	NO
VENEREAL DISEASE	YES	NO	(if yes, please explain) _____		
HEREDITARY DISEASE	YES	NO	OTHER SKIN PROB.	YES	NO
ASTHMA	YES	NO	(if yes, please explain) _____		

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 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 SYMPTOMS: PLEASE INDICATE ANY PERSONAL HISTORY OF CURRENTLY ACTIVE PROBLEMS.

CONSTITUTIONAL SYMPTOMS

Good general health	YES	NO
Recent weight change	YES	NO
Fever/Night sweats	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	YES	NO
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

INTEGUMENTARY (SKIN/BREASTS)

Problems w/ 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

ENDOCRINE

Glandular or hormone prob	YES	NO
Thyroid disease	YES	NO
Diabetes (insulin/non-insulin)	YES	NO

HEMATOLOGIC/LYMPHATIC

Taking blood thinners now	YES	NO
Slow to heal after cuts	YES	NO
Bleeding/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

GASTROINTESTIONAL

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 w/ 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 inf.	YES	NO
	Estrogen replace.	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

NEUROLOGIC

Frequent/recurring headaches	YES	NO
Lightheaded or dizzy	YES	NO
Convulsions/seizures	YES	NO
Stroke	YES	NO

PSYCHIATRIC

Nervousness	YES	NO
Depression	YES	NO
Other	YES	NO

ALLERGY/IMMUNOLOGY/INF. DISEASE

History of STD	YES	NO
History of HIV/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: _____

PATIENT INFORMATION SHEET

Patient name: _____

SSN: _____ DOB: _____ Male_____ Female_____

Home phone: _____ Cell phone: _____ Preferred: Home Cell

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email: _____

POLICY HOLDER (check if same as patient) _____

Name (if not patient): _____

Relationship to patient: Spouse_____ Parent_____ Other_____

Policy holders SSN: _____ DOB: _____ Male_____ Female _____

EMERGENCY CONTACT: _____

Relationship to patient: _____ Phone number: _____

SOCIAL HISTORY:

Marital status: _____

Use of alcohol: (circle one) None 1-2 drinks/day 3 or more/day

Use of tobacco: (circle one)

Never Former smoker Current every day smoker

Number of packs per day: _____ Total number of years smoking: _____

Use of drugs: Never Type/Frequency: _____

Are you sexually active?

No Yes, one partner Yes, multiple partners

Do you drive during the day? _____ Do you drive at night? _____

How often do you exercise? (circle one)

Never Once a day Several times a day Few times a week

Few times a month

What is your occupation and workplace? _____

What type of residence do you reside in: (home/apartment/asst. living...)

_____

What is your caffeine use: _____

Do you feel safe at home? (circle one) YES NO

PRACTICE ACKNOWLEDGEMENTS

SHONDRA L. SMITH, M.D.
3635 NELSON RD
LAKE CHARLES, LA 70605
(337) 477-0011

PATIENT NAME: _____

DATE OF BIRTH: _____

HIPAA ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided with 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 Dermatology and Advanced Aesthetics is an approved facility for dermatology services and obtain any referrals that my insurance company requires **prior** to my appointment. Dermatology and Advanced Aesthetics will file my medical claim as a courtesy. I understand that 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

_____ DATE: _____
SIGNED NAME OF PERSON WITH FINANCIAL RESPONSIBILITY

Shondra L. Smith, M.D.

DERMATOLOGY & ADVANCED AESTHETICS

DATE: _____

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

Due to HIPAA regulations, I hereby authorize the following names of those listed below to discuss and participate in my medical care (names of family members/friends who may be calling on your behalf; it is not necessary to list doctors' names.) I understand that if the names are not listed below, the office of Dermatology and Advanced Aesthetics can not release my information.

NAME	PHONE NUMBER	RELATIONSHIP

PATIENT SIGNATURE: _____ DATE: _____

3635 Nelson Rd * Lake Charles, LA 70605 * Phone (337) 477-0011* Fax (337) 477-0010