

SKINCARE PHYSICIANS™

Cosmetic Health History Form

TODAY'S DATE: _____

Name: _____
Last First Middle Initial

Address: _____
City State Zip

Date of Birth: _____ Age: _____ Sex: _____ SS# _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

OK to leave messages at: Home _____ Work _____ Cell _____

Email: _____ Occupation: _____

I give permission to SCP to discuss my medical/billing or scheduling information with the following people:

I agree that SkinCare Physicians may request and use my prescription medication history form other healthcare providers or third party pharmacy benefit payors for treatment purposes.

In case of an Emergency, who should be notified? _____

Phone: _____

Referred By: _____

Primary Care Physician: _____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. The patient is financially responsible for all cosmetic procedures. This office does not bill insurance companies for cosmetic procedures (not medically necessary). We accept payment in the form of cash, check or credit card.

SkinCare Physicians participates in a fellowship program for board certified/eligible dermatologists. These physicians may participate in your care.

Your signature below signifies your understanding and willingness to comply with our policies.

Patient Signature: _____

Date: _____

PLEASE TURN OVER

Health History

Reason for visit: _____

PAST MEDICAL HISTORY

Have you ever had the following: (circle "yes" if pertinent)

Measles	no	yes	Anemia	no	yes			
Hepatitis	no	yes	Bladder Infec.	no	yes			
High Blood Pressure	no	yes	Ulcer	no	yes	Chickenpox	no	yes
Epilepsy	no	yes	Low Blood Press.	no	yes	Kidney Disease	no	yes
Migraine Headache	no	yes	Back Trouble	no	yes	Heart Disease	no	yes
Thyroid Disease	no	yes	Tuberculosis	no	yes	Arthritis	no	yes
Date of last Chest X-ray			Bleeding Tendency	no	yes	Venereal Disease	no	yes
Diabetes	no	yes	Asthma	no	yes	Chemotherapy	no	yes
Cancer	no	yes	Pneumonia	no	yes	Any other disease(please list)		
AIDS/HIV+	no	yes	Rheumatic Fever	no	yes	_____		
Glaucoma	no	yes	Infectious Mono	no	yes	_____		
Hernia	no	yes	Bronchitis	no	yes	_____		
Blood/Plasma Transfusions	no	yes	Mitral Valve			_____		
Stroke			Prolapse	no	yes	_____		

SKIN PROBLEMS

Have you ever had any of the following? (please circle)

Melanoma/Skin Cancer/Unusual moles/Blistering Sunburns/Psoriasis/Eczema/Other: _____

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESS

When

Hospital, City, State

ARE YOU ALLERGIC TO ANY MEDICATIONS? (please list): _____

DO YOU TAKE ANY MEDICATIONS? (please list): _____

DO YOU TAKE(circle): Vitamin E/Aspirin/Motrin/Ibuprophen/Aleve/Coumadin/Bufferin/Excedrin/Other Blood Thinners _____

PATIENT SOCIAL HISTORY

Marital Status Single _____ Married/Partnered _____ Separated _____ Divorced _____ Widowed _____
Use of alcohol Never _____ Social _____ Moderate _____
Use of tobacco Never _____ Previously, but quit _____ Current packs/day _____

FAMILY HISTORY

Have any close relatives had any of the following? (please circle): Melanoma/Skin Cancer/Unusual moles/Severe acne/Psoriasis/other: _____

Physician Signature _____,MD

Date: _____