

**PATIENT INFORMATION**

\* Please write **CLEARLY** and include any apt. #'s, etc., your test results will be sent to this address.

Today's Date: \_\_\_\_\_ SS# (for insurance): \_\_\_\_\_  
Last Name: \_\_\_\_\_ Ins Copay: \_\_\_\_\_  
First Name: \_\_\_\_\_ Sex:  M  F  
Date of birth: \_\_\_\_\_ Marital Status:  S  M  W  D  DP  
\*Address: \_\_\_\_\_ Email (optional): \_\_\_\_\_  
\*City, State: \_\_\_\_\_ Occupation: \_\_\_\_\_  
\*Zip Code: \_\_\_\_\_ Work phone: \_\_\_\_\_ ext \_\_\_\_\_  
Home phone: \_\_\_\_\_ Phone to leave private message \_\_\_\_\_  
Spouse/Next of kin/Emergency contact information:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Primary Care Physician (name & phone #): \_\_\_\_\_  
Referring doctor (if applicable): \_\_\_\_\_  
Other referral source (ad, friend): \_\_\_\_\_

**MEDICATIONS AND MEDICATION ALLERGIES**

Allergies to Medications (pills, injectable drugs, creams, etc): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all of your oral and topical medications. Include over the counter medications that you use regularly, vitamins, minerals, herbal and other dietary supplements.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your **primary pharmacy**: Name \_\_\_\_\_  
Address or Phone \_\_\_\_\_

**SOCIAL HABITS**

Alcohol use: NO YES: Amount \_\_\_\_\_ Frequency \_\_\_\_\_ Quit \_\_\_\_\_  
Street drugs: NO YES: Marijuana \_\_\_\_\_ Methamphetamine \_\_\_\_\_ Other \_\_\_\_\_  
Smoking: NO YES: Amount \_\_\_\_\_ Years \_\_\_\_\_ Quit \_\_\_\_\_

**PERSONAL SKIN HISTORY**

\* Circle Y or N

- |     |                                 |     |                             |
|-----|---------------------------------|-----|-----------------------------|
| Y N | Actinic keratosis ("precancer") | Y N | Lupus erythematosus         |
| Y N | Acne                            | Y N | Melanoma: yr ____ site ____ |
| Y N | Basal Cell Carcinoma            | Y N | Psoriasis                   |
| Y N | Excessive hair growth           | Y N | Pigmentary problems         |
| Y N | Excessive sweating              | Y N | Rosacea                     |
| Y N | Eczema                          | Y N | Squamous Cell Carcinoma     |
| Y N | Hair loss                       | Y N | Keloid scarring             |

**FAMILY HISTORY**

Is there a family history of the following conditions:

- Y N Actinic keratosis ("precancer")
- Y N Acne
- Y N Basal Cell Carcinoma
- Y N Excessive hair growth
- Y N Excessive sweating
- Y N Eczema
- Y N Hair loss
- Y N Keloid scarring
- Y N Lupus erythematosus
- Y N Melanoma
- Y N Psoriasis
- Y N Pigmentary problems
- Y N Rheumatoid arthritis
- Y N Rosacea
- Y N Squamous Cell Carcinoma

Other Family History (skin or general): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**GENERAL MEDICAL HISTORY**

Please list medical problems, illnesses and major diagnoses in the left column and surgeries and other procedures in the column on the right.

DATE	PROBLEMS, ILLNESSES AND MAJOR DIAGNOSES	DATE	SURGERIES AND OTHER PROCEDURES

**CURRENT SKIN PROBLEM(S)**

Reason for visit (skin concerns/cosmetic)?

- 1. \_\_\_\_\_
  - a. Length of time (with issue) \_\_\_\_\_
  - b. Site \_\_\_\_\_
  - c. Past treatment \_\_\_\_\_
  - d. Severity \_\_\_\_\_
  - e. Other \_\_\_\_\_
  
- 2. \_\_\_\_\_
  - a. Length of time (with issue) \_\_\_\_\_
  - b. Site \_\_\_\_\_
  - c. Past treatment \_\_\_\_\_
  - d. Severity \_\_\_\_\_
  - Other \_\_\_\_\_
  
- 3. \_\_\_\_\_
  - a. Length of time (with issue) \_\_\_\_\_
  - b. Site \_\_\_\_\_
  - c. Past treatment \_\_\_\_\_
  - d. Severity \_\_\_\_\_
  - Other \_\_\_\_\_

**SYMPTOM REVIEW**

Are you having problems in these areas currently (or circle No)?

- Allergic \_\_\_\_\_ No
- Bleeding \_\_\_\_\_ No
- Breathing \_\_\_\_\_ No
- Heart \_\_\_\_\_ No
- Weight loss/gain \_\_\_\_\_ No
- Fevers, chills, sweats \_\_\_\_\_ No
- Thyroid/other endocrine \_\_\_\_\_ No
- Eye \_\_\_\_\_ No
- Stomach (GI) \_\_\_\_\_ No
- Female reproductive organs \_\_\_\_\_ No
- Male reproductive organs \_\_\_\_\_ No
- Joint/Back/Neck \_\_\_\_\_ No
- Neurologic \_\_\_\_\_ No
- Mood/Psychiatric \_\_\_\_\_ No
- Ears/Nose/Throat \_\_\_\_\_ No
- Other \_\_\_\_\_ No

**CLINICAL TRIALS**

**Name:** \_\_\_\_\_

MedDerm is involved in clinical research trials aimed at advancing and refining dermatologic therapeutics.

Would you (or your child) like to be contacted for clinical trials in the future?

Yes, please contact me (or my child) about a clinical trial for the following condition(S):

Psoriasis

Acne

Eczema

Rosacea

Lupus

Actinic Keratosis

Nail Fungus

Cosmetic Therapies

other \_\_\_\_\_

No thank you.

*MedDerm Associates, Inc.*

**SIGNATURE ON FILE AND FINANCIAL AGREEMENT**

I \_\_\_\_\_, acknowledge that MedDerm Associates, Inc. will bill the insurance company that I have provided information about on the day of my visit as a courtesy to me. However, as a patient, I am ultimately responsible for my medical bills if, for whatever reason, I become ineligible with this insurance company at the time of service, or if my insurance company denies payment for a procedure or service provided to me by MedDerm Associates, Inc.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PRIVACY PRACTICES – HIPAA**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

\_\_\_\_\_ I acknowledge that I can request a copy of the Notice of Privacy Practices that MedDerm Associates, Inc. has implemented.

\_\_\_\_\_ I acknowledge that MedDerm Associates, Inc. will keep a record of the health care services they provide for me. I may see and copy that record, and I may ask to correct the record if need arises.

\_\_\_\_\_ I am aware that MedDerm Associates, Inc. may disclose my health information to a physician or healthcare provider providing treatment to me, or to my insurance company to obtain payment for services. I acknowledge that MedDerm Associates, Inc. will not disclose any of my records unless I direct them to do so or unless the law authorizes or compels them to do so.

\_\_\_\_\_ I am aware that I may see my record or get more information about it by contacting:

MedDerm Associates, Inc.  
4065 Third Ave., Suite 102  
San Diego, CA 92103  
Tel# 619-542-0013

**Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access that information.**

By my signature below, I acknowledge

receipt of this Notice of Privacy Practices.

\_\_\_\_\_  
Signature of patient or authorized representative.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of representative signing on behalf of patient

\_\_\_\_\_  
Relationship to patient