DermaCare HI

P 808-855-8380
F 855-635-8353
E info@dermacarehi.com

Referals only fax
808-756-9551

Legal Name:_____Date: _____

Nickname:_____Date of Birth: _____ Gender: _____

Mailing Address: _____ City / State: _____ Zip Code: _____

Phone Number (day): _____ Phone Number (evening):_____

Email Address: _____

Emergency Contact: _____Relation: _____Phone Number:_____

Preferred Language: _____ Race: _____ Ethnic Group:_____

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

Primary Care Provider (Your Primary Doctor)

Name:_____

Phone:_____

City or Zip Code:_____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

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Past Surgical History

Have you had any surgeries on the following organs?

- [ ] Appendix (Appendectomy)
- [ ] Bladder (Cystectomy)
- [ ] Breast: Breast Biopsy
- [ ] Breast: Lumpectomy (Right, Left, Bilateral)
- [ ] Breast: Mastectomy (Right, Left, Bilateral)
- [ ] Colon (Colectomy): Colon Cancer Resection
- [ ] Colon (Colectomy): Diverticulitis
- [ ] Colon (Colectomy): Inflammatory Bowel Disease
- [ ] Colon: Colostomy
- [ ] Gallbladder (Cholecystectomy)
- [ ] Heart: Coronary Artery Bypass Surgery
- [ ] Heart: Heart Transplant
- [ ] Heart: Mechanical Valve Replacement
- [ ] Heart: PTCA
- [ ] Joint Replacement: Hip (Right, Left, Bilateral)
- [ ] Joint Replacement: Knee (Right, Left, Bilateral)
- [ ] Kidney: Kidney Biopsy
- [ ] Kidney: Kidney Stone Removal
- [ ] Kidney: Kidney Transplant
- [ ] Kidney: Nephrectomy
- [ ] Liver: Hepatectomy
- [ ] Liver: Liver Transplant
- [ ] Liver: Shunt
- [ ] Ovaries (Oophorectomy): Endometriosis
- [ ] Ovaries (Oophorectomy): Ovarian Cancer
- [ ] Ovaries (Oophorectomy): Ovarian Cyst
- [ ] Ovaries: Tubal Ligation
- [ ] Pancreas: Pancreatectomy
- [ ] Prostate (Prostatectomy): Prostate Biopsy
- [ ] Prostate (Prostatectomy: Prostate Cancer
- [ ] Prostate (Prostatectomy): TURP
- [ ] Rectum: APR
- [ ] Rectum: Low Anterior Resection
- [ ] Skin: Basal Cell Carcinoma
- [ ] Skin: Melanoma
- [ ] Skin: Skin Biopsy
- [ ] Skin: Squamous Cell Carcinoma
- [ ] Spleen (Splenectomy)
- [ ] Testicles (Orchiectomy)
- [ ] Uterus (Hysterectomy): Fibroids
- [ ] Uterus (Hysterectomy): Uterine Cancer
- [ ] Uterus (Hysterectomy): Cervical Cancer
- [ ] NONE
- [ ] Other

_____
_____
_____

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Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis (frozen with liquid nitrogen)
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other

_____
_____

Do you wear Sunscreen?

◯ Yes ◯ No

If yes, what SPF? _____

Do you tan in a tanning salon?

◯ Yes ◯ No

Do you have a family history of Melanoma?

◯ Yes ◯ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

_____
_____

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Medications (include over the counter medications, vitamins and supplements)

List all current medications:

_____
_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker (please state how many years below)
- ☐ Never smoker

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ < 1 drink per day
- ☐ 1-2 per day
- ☐ 3 or more per day

How many days in the past year have you consumed the following:
MEN: 5 or more alcoholic drinks in 1 day? _____
WOMEN: 4 or more alcoholic drinks in 1 day? _____

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

Have you received your influenza (flu) vaccination?

☐ YES ☐ NO

If yes, when? (month & year) _____

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Quality measure: Have you received your pneumonia vaccination? (for adults 65 and older) ☐ YES ☐ NO

In an event that you are unable to make your own medical decisions, **Do you have a Healthcare Proxy?** ☐ YES ☐ NO

(*Someone designated* to make health care decisions for you) If YES, please state name & relationship:_____

Do you have a Living Will? (*a written statement detailing* a person's desires regarding their medical treatment, in circumstances in which they are unable to make for themselves) ☐ YES ☐ NO

Family History of Disease or Illness: Please include only first-degree relatives:

_____

_____

Review of Systems

Do you have any of the following symptoms today?

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring
- ☐ Rash
- ☐ Hay fever
- ☐ Chest Pain
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Thyroid problems
- ☐ Sore throat
- ☐ Blurry vision
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Neck Stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression
- ☐ NONE
- ☐ Other_____
  _____
  _____

Occupation & Workplace:

If retired, state previous occupation _____

_____

_____

Do you work Indoors or Outdoors? (circle one)

Alerts

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within the past 2 years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA or history of MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning a pregnancy
- ☐ Immunosuppression
- ☐ Porphyria cutanea tarda
- ☐ Spinal cord stimulator
- ☐ NONE
- ☐ Other_____
  _____
  _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/ date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- The practice will be requesting prescription history information for the patient for the purpose of providing direct healthcare services.

CIRCLE ONE: May we **phone, email**, or send a **text** to you to confirm appointments?	**YES**	**NO**
May we leave a message on your answering machine at home or on your cell phone?	**YES**	**NO**
May we discuss your medical condition with any member of your family?	**YES**	**NO**

If YES, please state NAME & RELATIONSHIP we are allowed to speak with:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature:_____ Date:_____

Witness:_____ Date:_____