

Loma Linda Dermatology Medical Group

Patient Medical History Questionnaire

Patient Name:	Last, _____, First _____	Date:	
Date of Birth:		Age:	
		Sex:	M F
Address:		City, State, Zip	
Nearest Relative/ Emergency Contact:		()	Email:
Please <i>initial</i> the next to the locations where we may leave a message with private information such as a biopsy result:			
Phone: _____	Home: ()	Work: ()	Cell: ()
Referred by (Name, Phone #)?			
Who is your primary care doctor? (Address and Phone Number)			
For what problem are you being seen today? How long has it been there?			
Past treatments for this problem?			
List, or provide a list, of all medications you are currently taking (prescription and non-prescription)	1.	2.	
	3.	4.	
	5.	6.	
	7.	8.	
List all allergies (to medications or latex , etc):			
List all known medical conditions (e.g. diabetes, high blood pressure)			
Do you have a history of skin cancer? If yes, what type?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Basal Cell <input type="checkbox"/> Squamous Cell
			<input type="checkbox"/> Melanoma <input type="checkbox"/> Other _____
Do you take blood thinners? Aspirin? Coumadin?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	What type?
Do you have any implantable devices (e.g. pacemaker, artificial joint, defibrillator) ?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	What type?
Have you had any recent cosmetic or elective treatments to your skin?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	What type?

Have you or anyone in your family had or have any of these problems?

PROBLEM	PATIENT	FAMILY
GLAUCOMA	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
HEART TROUBLE	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
ABNORMAL EKG (HEART TEST)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
BLOOD VESSEL DISEASE (PHLEBITIS)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
ASTHMA LUNG DISEASE	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
TUBERCULOSIS	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
ABNORMAL CHEST X-RAY	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
ABNORMAL BLEEDING	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
BLOOD DISEASE (ANEMIA)	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
BLOOD TRANSFUSION, when?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
ARE YOU HIV POSITIVE	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
DIABETES	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
HEPATITIS	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
STOMACH PROBLEMS	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
KIDNEY DESEASE	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
BACK OR NECK PROBLEMS	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
SEIZURES	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
FAINTING	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
PARALYSIS	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
STROKE	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
DEPRESSION	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
INSOMNIA	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
HEADACHES	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
FREQUENT INFECTIONS	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
DRY SKIN OR SKIN RASH	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
HIVES OR ITCHING OF THE SKIN	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
EXCESSIVE SWEATING	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
EXCESSIVE BLEEDING AFTER CUTTING SKIN OR BLEEDING DISORDER	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
SKIN CANCER	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
MALIGNANT MELANOMA	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
HAVE YOU HAD AN ATYPICAL MOLE	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
HAVE YOU EVER HAD A REACTION TO AN ANESTHETIC?	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

Occupation:

Do you smoke? No Yes , Packs/day: _____ **Drink alcohol?** No Yes , How often?

If you have medical insurance, we wish to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance, and understanding of our financial policy:

We are contracted with many insurance companies. If you have a question regarding whether we are contracted with your plan please contact your insurance company as they can best answer this question. In order to be able to file insurance claims, we must have a copy of your insurance card. **Please notify us if your insurance plan or coverage has changed.** Without this information, we will be unable to submit your claim to your insurance for payment.

Your insurance coverage is a contract between you and/or your employer, and the insurance company. We are not party to that contract..

Some insurance companies require that **prior to each visit you must obtain an authorization or referral from your primary care physician.** If this is not done by the time of your appointment, you will be asked to either reschedule your appointment and contact your PCP, or pay for the services at the time you are seen. Any payments made at the time of service will be promptly refunded upon receipt of payment by the insurance company. Please be aware that most insurance companies will only cover the cost of the services listed on the authorization. Any services which are not authorized or denied by your insurance company are your responsibility.

Co-payments, if required by your plan, are due at the time of each visit. Please come prepared to pay the copay amount as determined by your insurance plan (most copays are listed on your insurance card). Most insurance companies require that this amount be paid at the time of service to validate the contract.

No matter what type of plan you have (HMO, PPO, POS, or Indemnity) it is to your advantage, as well as your responsibility, to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts. Contact your insurance company to find out what benefits are covered under your plan. **We will work unpaid insurance claims for 90 days and then the balance will become the patient's responsibility.** You are responsible for payment of any deductible amounts and non-covered services.

We request that as a courtesy to other patients, that you **notify us at least 24 hours in advance if you will be unable to keep your appointment.** We reserve the right to charge for any appointment which is not canceled with proper notice.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Therefore, all cost for services provided remain the responsibility of the patient/guarantor from the date the service is rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account.

All patient balances over 30 days old will be charged 1.5% interest monthly.

If paying by check, there will be a \$25.00 charge for all checks returned for insufficient funds.

Notice of Privacy Practices: It is the policy of K.D. Macknet, M.D., Inc not to release any medical information except as legally required or specifically authorized by the patient.

Authorization for release of information: I hereby authorize K.D. Macknet, M.D., Inc. to release any and all medical information for the purposes of treatment, payment and healthcare operations. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it.

Assignment of Insurance Benefits: I hereby assign to K.D. Macknet, M.D. Inc. all money to which I am entitled to for medical and/or surgical expense relative to the services rendered, but not to exceed my indebtedness to K.D. Macknet, M.D., Inc. It is understood that any money received from my insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to K.D. Maknet, M.D., Inc. for charges not covered by this assignment. I further agree that in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees, should this be required. Writing a bad check is against the law. Recipients of bad checks may sue the Payer in Small Claims court for three times the amount of the check or \$100, whichever is more. In addition, suit may be made against the Payer for the face value of the check and all court costs. (California Civil code, Chapter 522, Section 1719)

X _____
PATIENT SIGNATURE (guarantor, if patient is a minor)

Name: _____ **Date:** _____

Are you currently experiencing any of the symptoms listed below?

Skin

- | | | | |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> rash | <input type="checkbox"/> itching | <input type="checkbox"/> skin dryness | <input type="checkbox"/> pigmentation changes |
| <input type="checkbox"/> nail changes | <input type="checkbox"/> new skin lesion(s) | <input type="checkbox"/> change in existing skin lesion | |
| <input type="checkbox"/> acne | <input type="checkbox"/> ingrown nails | <input type="checkbox"/> yellowing of skin | <input type="checkbox"/> change in hair growth |

Constitutional

- | | | | |
|--------------------------------------|---|-------------------------------------|---|
| <input type="checkbox"/> fatigue | <input type="checkbox"/> malaise | <input type="checkbox"/> body aches | <input type="checkbox"/> loss of appetite |
| <input type="checkbox"/> weight loss | <input type="checkbox"/> night sweats | <input type="checkbox"/> fever | <input type="checkbox"/> chills |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> significant weight changes | | |

Eyes

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> discharge from eye | <input type="checkbox"/> eye discomfort | <input type="checkbox"/> eye pain | <input type="checkbox"/> double vision |
| <input type="checkbox"/> impaired vision | <input type="checkbox"/> blurred vision | <input type="checkbox"/> focal vision loss | <input type="checkbox"/> peripheral vision changes |
| <input type="checkbox"/> decreased night vision | | <input type="checkbox"/> yellowing of the white part of the eye | |

HEENT

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> headaches | <input type="checkbox"/> vertigo | <input type="checkbox"/> lightheadedness | <input type="checkbox"/> recent head injury |
| <input type="checkbox"/> sinus pain | <input type="checkbox"/> nasal congestion | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> nasal discharge |
| <input type="checkbox"/> postnasal drip | <input type="checkbox"/> gingival bleeding | <input type="checkbox"/> dental problems | <input type="checkbox"/> dentures |
| <input type="checkbox"/> neck stiffness | <input type="checkbox"/> neck pain | <input type="checkbox"/> neck tenderness | <input type="checkbox"/> thyroid mass |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> breath odor | | |

Breasts

- | | | | |
|--|-------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> lumps | <input type="checkbox"/> tenderness | <input type="checkbox"/> swelling | <input type="checkbox"/> nipple discharge |
| <input type="checkbox"/> abnormal changes in breasts | | | |

Cardiovascular

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> rapid hear rate | <input type="checkbox"/> dizziness | <input type="checkbox"/> pain in legs with exercise |
| <input type="checkbox"/> leg swelling | <input type="checkbox"/> varicosities | <input type="checkbox"/> lightheadedness | <input type="checkbox"/> irregular heart beats |
| <input type="checkbox"/> firm swelling over veins | <input type="checkbox"/> dizziness with standing | | <input type="checkbox"/> shortness of breath on exertion |

Respiratory

- | | | | |
|--|--|--|-------------------------------------|
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> wheezing | <input type="checkbox"/> chronic cough | <input type="checkbox"/> hoarseness |
| <input type="checkbox"/> blood in sputum | <input type="checkbox"/> pain with breathing | | |

Gastrointestinal

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> nausea | <input type="checkbox"/> vomiting | <input type="checkbox"/> diarrhea | <input type="checkbox"/> constipation |
| <input type="checkbox"/> loss of appetite | <input type="checkbox"/> heart burn | <input type="checkbox"/> vomiting blood | <input type="checkbox"/> problems swallowing |
| <input type="checkbox"/> abdominal pain | <input type="checkbox"/> yellowing of skin | <input type="checkbox"/> blood in stools | <input type="checkbox"/> black tarry stools |

Genitourinary

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> frequency | <input type="checkbox"/> pain with urinating | <input type="checkbox"/> genital sores | <input type="checkbox"/> possible pregnancy |
| <input type="checkbox"/> blood in urine | <input type="checkbox"/> irregular menses | <input type="checkbox"/> frequent nighttime urination | |

Neurologic

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> muscle weakness | <input type="checkbox"/> memory difficulties | <input type="checkbox"/> headaches | <input type="checkbox"/> difficulty concentrating |
| <input type="checkbox"/> incoordination | <input type="checkbox"/> speech difficulties | <input type="checkbox"/> loss of balance | |

Musculoskeletal

- | | | | |
|---|--|--------------------------------------|------------------------------------|
| <input type="checkbox"/> joint pain | <input type="checkbox"/> muscle cramps | <input type="checkbox"/> muscle pain | <input type="checkbox"/> back pain |
| <input type="checkbox"/> joint swelling | <input type="checkbox"/> muscle weakness | | |

Psychiatric

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> anxiety | <input type="checkbox"/> depression | <input type="checkbox"/> excessive anger | <input type="checkbox"/> difficulty sleeping |
| <input type="checkbox"/> impulsive behaviors | <input type="checkbox"/> thoughts of hurting yourself | | <input type="checkbox"/> thoughts of hurting others |