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 *initial* 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?	☐ No	☐ Yes	☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ Other _____
Do you take blood thinners? Aspirin? Coumadin?	☐ No	☐ Yes	What type?
Do you have any implantable devices (e.g. pacemaker, artificial joint, defibrillator) ?	☐ No	☐ Yes	What type?
Have you had any recent cosmetic or elective treatments to your skin?	☐ No	☐ Yes	What type?

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

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

<u>Skin</u>

- ☐ rash ☐ itching ☐ skin dryness ☐ pigmentation changes
- ☐ nail changes ☐ new skin lesion(s) ☐ change in existing skin lesion
- ☐ acne ☐ ingrown nails ☐ yellowing of skin ☐ change in hair growth

<u>Constitutional</u>

- ☐ fatigue ☐ malaise ☐ body aches ☐ loss of appetite
- ☐ weight loss ☐ night sweats ☐ fever ☐ chills
- ☐ weight gain ☐ significant weight changes

<u>Eyes</u>

- ☐ discharge from eye ☐ eye discomfort ☐ eye pain ☐ double vision
- ☐ impaired vision ☐ blurred vision ☐ focal vision loss ☐ peripheral vision changes
- ☐ decreased night vision ☐ yellowing of the white part of the eye

<u>HEENT</u>

- ☐ headaches ☐ vertigo ☐ lightheadedness ☐ recent head injury
- ☐ sinus pain ☐ nasal congestion ☐ nose bleeds ☐ nasal discharge
- ☐ postnasal drip ☐ gingival bleeding ☐ dental problems ☐ dentures
- ☐ neck stiffness ☐ neck pain ☐ neck tenderness ☐ thyroid mass
- ☐ sore throat ☐ breath odor

<u>Breasts</u>

- ☐ lumps ☐ tenderness ☐ swelling ☐ nipple discharge
- ☐ abnormal changes in breasts

<u>Cardiovascular</u>

- ☐ chest pain ☐ rapid hear rate ☐ dizziness ☐ pain in legs with exercise
- ☐ leg swelling ☐ varicosities ☐ lightheadedness ☐ irregular heart beats
- ☐ firm swelling over veins ☐ dizziness with standing ☐ shortness of breath on exertion

<u>Respiratory</u>

- ☐ shortness of breath ☐ wheezing ☐ chronic cough ☐ hoarseness
- ☐ blood in sputum ☐ pain with breathing

<u>Gastrointestinal</u>

- ☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation
- ☐ loss of appetite ☐ heart burn ☐ vomiting blood ☐ problems swallowing
- ☐ abdominal pain ☐ yellowing of skin ☐ blood in stools ☐ black tarry stools

<u>Genitourinary</u>

- ☐ frequency ☐ pain with urinating ☐ genital sores ☐ possible pregnancy
- ☐ blood in urine ☐ irregular menses ☐ frequent nighttime urination

<u>Neurologic</u>

- ☐ muscle weakness ☐ memory difficulties ☐ headaches ☐ difficulty concentrating
- ☐ incoordination ☐ speech difficulties ☐ loss of balance

<u>Musculoskeletal</u>

- ☐ joint pain ☐ muscle cramps ☐ muscle pain ☐ back pain
- ☐ joint swelling ☐ muscle weakness

<u>Psychiatric</u>

- ☐ anxiety ☐ depression ☐ excessive anger ☐ difficulty sleeping
- ☐ impulsive behaviors ☐ thoughts of hurting yourself ☐ thoughts of hurting others