Nashville Dermatology
PHYSICIANS

Patient Information

Welcome! This questionnaire collects information about your **current state of health** to assist the doctors with your care and help them meet requirements established by Medicare and other insurers. This information and your signature will be stored electronically and reformatted for your medical record.

Answer **ALL** questions by filling in the appropriate circle(s) and/or by **PRINTING** the requested information in the appropriate box.

Patient Name: _____ Birth date: _____-_____-_____

Social Security #: _____ - _____- _____ Parent/Legal Guardian: _____

Preferred Phone: (_____)_____

Address: _____ City/State/Zip: _____

Emergency Contact: _____ _____
(Name) (Relationship)

(_____)_____ (_____)_____
(Telephone) (Optional alternate telephone)

E-mail: _____@_____._____

Primary Care Physician: _____ _____
(Name) (City and/or phone #)

Permission is granted to text or email appointment reminders and messages unless indicated:

O No text or email appointment reminders

Please initial:

_____I hereby acknowledge that I have read and understand the policy on protected health information posted by Nashville Dermatology Physicians.

_____Nashville Dermatology Physicians has my authorization to request protected health information from outside health care facilities and/or personnel in order to facilitate the implementation of any relevant diagnosis and treatment.

_____I request that authorized payment(s) on my behalf from Medicare, Medigap plans and certified private insurance carriers be made payable to Nashville Dermatology Physicians or its parent company Dermatology & Dermatologic Surgery, Ltd.

_____I understand that insurance plan deductible obligations and any other outstanding account balance will be collected before additional services are rendered.

REASON FOR TODAY'S VISIT: _____

Allergies

Are there medications to which you have had an allergic reaction or unpleasant side effects?

O No O Yes→ If yes, please describe in space below.
If more space is needed, bring a list to your appointment.

Name of Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Have you had a reaction to any of the following? O No allergy to any of these or other items

O Adhesive Tape O Iodine or X-ray contrast O Soaps/Detergents

O Fragrance O Latex or rubber O Other _____

Do you have any food allergies? O No O Yes → Bring a list to your appointment.

Medications

Please list any prescription and/or non-prescription medications ***including*** vitamins, nutritional supplements, oral contraceptives, pain relievers, laxatives, herbal therapy and cold medications you are currently taking.

O I am not taking any medications

Name of Medication	Dose (Strength)	How Often Taken (Ex. twice daily)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken aspirin-containing products in the last two weeks? O No O Yes

Do you take antibiotics prior to dental work or any other procedure? O No O Yes

Past Medical History

Have you ever been diagnosed with any of the following infectious diseases?

Hepatitis A	O No	O Yes
Hepatitis B	O No	O Yes
Hepatitis C	O No	O Yes
Varicella (chickenpox or shingles)	O No	O Yes
Human Immunodeficiency Virus	O No	O Yes
Lyme Disease	O No	O Yes
Mononucleosis (Epstein-Barr Virus)	O No	O Yes
Tuberculosis	O No	O Yes
Resistant Staph Infection (MRSA)	O No	O Yes

Indicate if you have ever sought medical care or had a **medical problem** or **surgery** related to the following:

The interviewing Nurse will record the dates of diagnosis/surgery, if known.

O Anemia/ Leukemia	O Genetic disorder(s)	O Lung/Pulmonary disorder/Sarcoidosis
O Artery or Vein problems	O Glaucoma/Blepharitis	O Lymph gland disorders/Lymphoma
O Bladder Dysfunction	O Artificial joint	O Muscle weakness
O Blood clotting issues	O Heart/Valve Issues	O Neurologic: MS/Alzheimer's/Neuropathy
O Bone Disorder/Osteoporosis	O High Blood Pressure	O Pancreatitis/Reflux
O Bowel/Intestine disorder	O High cholesterol/triglycerides	O Psoriasis
O Brain cancer/disorder	O Hormone Disorders	O Psychiatric illness
O Breast cancer	O Joints/Rheumatoid Arthritis	O Skin Cancer → Type: _____
O Depression/Anxiety	O Kidney disease/stones	O Stomach/Ulcer/Digestive Problems
O Diabetes/Hypoglycemia	O Liver disease	O Stroke/TIA
O Eczema	O Lupus/Autoimmune disorder	O Thyroid or Parathyroid disorder

O Not Listed:_____

Females:	Might you be pregnant at this time?	O No O Yes
	Are you able to get pregnant? (E.g. Hysterectomy/Menopause)	O No O Yes
	Are you currently breast feeding?	O No O Yes
	Have your menstrual periods become irregular/abnormal?	O No O Yes

***** Please inform the nurse if you feel that you have any other pertinent medical information not listed above *****

Family History

If known, fill in the appropriate circles to identify the condition that has occurred in your blood relatives.

Indicate "NONE" if you are unsure or do not know → O None

O Allergies/Hives	O Diabetes	O Psoriasis
O Anemia	O Eczema	O Rheumatoid Arthritis
O Anesthesia Complications	O Heart disease	O Seizures
O Arthritis	O High blood pressure	O Skin cancer Type: _____
O Breast Cancer	O Liver disease	O Stomach ulcers
O Clotting disorder	O Lung Cancer	O Stroke
O Depression	O Lupus	O Other Psychiatric Illness

O Other Cancer: _____

O Other Condition: _____

Social History

Do you smoke or Vape?	O No	O Yes
Do you drink alcohol regularly?	O No	O Yes
Do you use illicit drugs?	O No	O Yes

Systems Review

Fill in the circle to the left of each symptom that you are currently experiencing. Indicate "NONE" if you are not experiencing any of the symptoms in each group.

O Arms/ Legs weakness	O Exposure to tuberculosis (TB)	O Seizures
O Change in bowel function	O Fever within the last two weeks	O Shortness of breath
O Chest pain/pressure	O Headaches	O Sinus problems
O Coughing	O Itching/Burning skin	O Swelling feet
O Difficulty urinating	O Joint pain/swelling	O Suicidal thoughts
O Dizziness	O Muscle pain/stiffness	O Weight gain/loss (10 lbs or more)
O Excessive bruising	O Nausea/vomiting	O Wheezing
O Excessive thirst	O Numbness in hands/arms/legs	O Unusual sadness/ nervousness

O None/ No Symptoms

BRING ANY ADDITIONAL INFORMATION THAT YOU FEEL IS RELEVENT FOR THE DOCTOR

Return this form to the front desk when it is complete