WEST TEXAS DERMATOLOGY CENTER

Today's Date ____/____/____ Referring Doctor: _____

Patient Name _____
Last First MI

Address_____City_____State_____Zip_____

Home Phone_____ Work Phone_____ Cell Phone _____

Date of Birth ____/____/____ Sex: M or F ____ Age _____

Social Security # _____ Place of Birth (city & state)_____

Employer/School _____ Occupation_____

Spouse/Parent(s) Name _____ Marital Status _____

Email address (for specials/monthly newsletters): _____

*********PLEASE GIVE RECEPTIONIST YOUR INSURANCE CARD(S)*********

Insurance Company _____ Employer _____

Subscriber's Name _____ Address __ _____

Date of Birth ___/___/___ Social Security# _____ Relation to patient _____

Group# _____ ID# _____

****

PLEASE NOTE: IN THE EVENT THAT A BIOPSY IS PERFORMED DURING YOUR VISIT, THE SPECIMEN WILL BE SENT TO AN OUTSIDE LABORATORY FOR A PATHOLOGICAL DIAGNOSIS. YOU WILL BE BILLED SEPERATELY FOR THE SERVICE FROM THE PATHOLOGIST.

The above information is true to the best of my knowledge.
I authorize the release of any medical or other information necessary for the purpose of treatment, payment, and health care operations. I also authorize payment of medical benefits to the physician or practice.

_____
PATIENT

_____
PARENT IF PATIENT IS A MINOR (under the age of 18)

Kris L. Howard, M.D.
Nicole L. Connelly, PA-C
8141 Dorado Drive Odessa, TX 79765
432-563-3113
432-563-4206 fax

PAST MEDICAL HISTORY

Reason for today's visit _____

Select any of the following medical conditions that you currently have.

- o Anxiety
- o Arthritis
- o Asthma
- o Atrial Fibrillation (irregular heartbeat)
- o BHP
- o Bone Marrow Transplantation
- o Breast Cancer
- o Colon Cancer
- o COPD
- o Coronary Artery Disease
- o Depression
- o Diabetes
- o End State Renal Disease
- o GERD
- o Other:_____
- o Hearing Loss
- o Hepatitis
- o Hypertension
- o HIV/AIDS
- o Hypercholesterolemia
- o Hyperthyroidism
- o Hypothyroidism
- o Leukemia
- o Lung Cancer
- o Lymphoma
- o Prostate Cancer
- o Radiation Treatments
- o Seizures
- o Stroke
- o None

PAST SURGERIES

Select any of the following medical conditions that you currently have

- o Appendix (Appendectomy)
- o Bladder (Cystectomy)
- o Breast (Lumpectomy) circle one: **BOTH BREAST LEFT BREAST RIGHT BREAST**
- o Breast (Mastectomy) circle one: **BOTH BREAST LEFT BREAST RIGHT BREAST**
- o Colon (Colectomy) circle one: **COLON CANCER RESECTION DIVERTICULITS IBS**
- o Colon (Colostomy)
- o Gall Bladder (Cholecystectomy)
- o Heart circle one: **BIOLOGICAL VALVE REPLACEMENT CORONARY ARTERY BYPASS TRANSPLANT MECHANICAL VALVE REPLACEMENT PTCA**
- o Joint Replacement circle one: **HIP: BOTH LEFT RIGHT KNEE: BOTH LEFT RIGHT**
- o Kidney circle one: **BIOPSY STONE REMOVAL TRANSPLANT NEPHRECTOMY**
- o Liver circle one: **HEPATECTOMY TRANSPLANT SHUNT**
- o Ovaries (Oophorectomy) circle one: **ENDOMETRIOSIS OVARIAN CANCER OVARIAN CYST**
- o Ovaries (Tubal Ligation)
- o Pancreas (Pancreatectomy)
- o Prostate (Prostatectomy) circle one: **BIOPSY CANCER TURP**

Continue on next page

Kris L. Howard, M.D.
Nicole L. Connelly, PA-C
8141 Dorado Drive Odessa, TX 79765
432-563-3113
432-563-4206 fax

- o Rectum circle one: **APR** **LOWER ANTERIOR RESECTION**
- o Skin circle one: **BASAL CELL** **MELANOMA** **BIOPSY** **SQUAMOUS CELL**
- o Spleen (Splenectomy)
- o Testicles (Orchiectomy)
- o Uterus (Hysterectomy) circle one: **Fibroids** **Uterine Cancer** **Cervical Cancer**
- o Other _____
- o None

SKIN DISEASE HISTORY

Have you had any of the following skin conditions?

- o Acne
- o Actinic Keratoses
- o Asthma
- o Basal Cell Carcinoma
- o Blistering Sunburns
- o Dry Skin
- o Eczema
- o Other: _____
- o Flaking or Itching Scalp
- o Hay Fever / Allergies
- o Melanoma
- o Poison Ivy
- o Precancerous Moles
- o Psoriasis
- o Squamous Cell Carcinoma
- o None

DO YOU WEAR SUNSCREEN:

o YES o NO

If yes, what SPF:_____

DO YOU TAN IN A TANNING SALON:

o YES o NO

MEDICATION HISTORY

Are you currently taking any over the counter medications:

o YES o NO

List:

_____

Are you currently taking any Prescription Medications? o Yes o No

If yes, please list: **PLEASE INCLUDE THE STRENGTH AND FREQUENCY**

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Continue on next page

Kris L. Howard, M.D.
Nicole L. Connelly, PA-C
8141 Dorado Drive Odessa, TX 79765
432-563-3113
432-563-4206 fax

ALLERGIES

Are you allergic to any medications: o Yes o No

If yes to What:

_____

Have you ever had dental anesthesia (Lidocaine) o Yes o No

If so: Any bad reaction o Yes o No

SMOKING HISTORY

Choose One

- o Current every day smoker
- o Current some day smoker
- o Former smoker
- o Never smoker
- o Unknown if ever smoked

SOCIAL HISTORY

- o Not sexually active
- o Sexually active
- o Drug use
- o IV Drug use
- o Other_____

- o EtOH none
- o EtOH less than 1 drink per day
- o EtOH 1 – 2 drinks per day
- o EtOH 3 or more drinks per day
- o None

FAMILY HISTORY

Do you have a family history of Skin Cancer? o Yes o No

Circle one **Melanoma** **Basal Cell Carcinoma** **Squamous Cell Carcinoma**

If yes, which relative?

- o Mother
- o Father
- o Sister
- o Brother
- o Daughter
- o Son
- o Aunt
- o Uncle
- o Nephew
- o Niece
- o Grandmother
- o Grandfather
- o Grandson
- o Granddaughter
- o Other _____
- o None

Continued on next page

Kris L. Howard, M.D.
Nicole L. Connelly, PA-C
8141 Dorado Drive Odessa, TX 79765
432-563-3113
432-563-4206 fax

PRIMARY REVIEW OF SYMPTOMS

Do you have any on the following?

- Problems with bleeding
- Problems with healing (hypertrophic or keloids)
- Problems with scarring
- Rash
- Immunosuppression
- Hay Fever
- Chest Pain
- Fever or chills
- Night Sweats
- Unintentional Weight Loss
- Thyroid Problems
- Sore Throat
- Blurry Vision
- Abdominal Pain
- Neck stiffness
- Seizures
- Cough
- Shortness of Breath
- Wheezing
- Anxiety
- Depression
- Other _____

ALERTS

Do you have any of the following?

- Pacemaker
- Defibrillator
- Artificial Joint within the past two years
- Artificial Heart Valve
- Premedication prior to procedures
- Allergy to adhesive
- Allergy to topical antibiotic ointments
- Blood Thinners
- Pregnant or planning to become pregnant
- Breast Feeding
- Allergy to lidocaine
- Rapid heartbeat with epinephrine
- Yeast infections with antibiotics
- GI upset with antibiotics

Which Pharmacy and location do you use? _____

Do you give our office permission to discuss your medical information with family members?

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

Kris L. Howard, M.D.
Nicole L. Connelly, PA-C
8141 Dorado Drive Odessa, TX 79765
432-563-3113
432-563-4206 fax

Patient: _____ Date of Birth: ____/____/____ Today's Date: _____

Due to government regulations concerning <u>Medicare patients</u>, we must ask these questions at every visit.

Have you received a Pneumonia vaccination within the last 5 years? YES NO

- If yes, when _____

Have you received a Flu Shot within the last year? YES NO

- If yes, when _____

Have you fallen within the past 12 months? YES NO

- If yes, when _____

Do you smoke? YES NO

- If no, have you ever smoked? YES NO

Do you drink Alcohol? YES NO

- If yes, how much and how often _____
- Have you ever tried to cut back on your use? YES NO
- Have you ever felt guilty about your use? YES NO
- Have you ever had an eye opener to get you started in the morning? YES NO

Kris L. Howard, M.D.
Nicole L. Connelly, PA-C
8141 Dorado Drive Odessa, TX 79765
432-563-3113
432-563-4206 fax