

Skin Surgery Center of Houston

PATIENT MEDICAL HISTORY

This information is considered confidential as part of a patient/physician relationship. THE INFORMATION, PROVIDED BELOW WILL NOT BE RELEASED WITHOUT YOUR WRITTEN AUTHORIZATION. Please answer completely and accurately to the best of your knowledge.

Name: _____
First Middle Initial Last

Reason for Consultation? _____

Height _____ Weight _____ Age _____

Pharmacy _____ Address or Cross Streets _____ Phone _____

Please list any previous surgeries or accidents: _____

Do you have a family history of skin cancer? _____

Do you have a family history of cancer? _____

Do you have or have you had any of the following? Please circle yes or no.

Asthma	Yes	No	Seizures	Yes	No	Heartburn	Yes	No
Bronchitis	Yes	No	Stroke	Yes	No	Ulcers	Yes	No
Emphysema	Yes	No	Kidney Disease	Yes	No	Stomach Problems	Yes	No
Breathing Difficulty	Yes	No	Dizziness	Yes	No	Intestinal Problems	Yes	No
Pneumonia	Yes	No	Tuberculosis	Yes	No	Hay Fever	Yes	No
High Blood Pressure	Yes	No	Liver Disease	Yes	No	Depression	Yes	No
Heart Disease	Yes	No	Cirrhosis	Yes	No	Cancer	Yes	No
Heart Attack	Yes	No	HIV/AIDS	Yes	No	Sinus Problems	Yes	No
Chest Pain	Yes	No	Hepatitis	Yes	No	Headaches	Yes	No
Diabetes	Yes	No	Thyroid Problems	Yes	No	Migraines	Yes	No
Pacemaker/Defibrillator	Yes	No	Fever Blisters	Yes	No	Arthritis	Yes	No

Have you had a Covid vaccine? Yes No

Please list all medications you are currently taking: _____

Do you take Aspirin, Coumadin, Plavix, or any other blood thinners? _____

Any known allergies? (Please list) _____

Are you a smoker? _____ If so, how much? _____ Do you drink alcohol? _____ If so, how much? _____

For patients 65 and older ONLY- Have you had the pneumonia vaccine since turning 65? Yes No

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PATIENT QUESTIONNAIRE AND HIPAA ACKNOWLEDGEMENT

Patient Name (print): _____ **Date:** _____

You may be contacted by the practice to remind you of appointments, healthcare treatment options or other health services that may be of interest to you.

Do we have permission to:

Leave a message on your answering machine at home? ___ Yes ___ No

Leave a message on your cell phone? ___ Yes ___ No

Leave a message at your place of employment? ___ Yes ___ No

Discuss your medical condition with a family member? ___ Yes ___ No

If yes, who? _____ Relationship _____ Telephone _____

Comment: _____

Skin Surgery Center of Houston has provided me with a copy of my rights (find a copy on our web site or ask for a copy in the office) as a patient under the HIPAA act. I have been provided the opportunity to read and understand my rights and ask questions regarding my rights and receive answers to my satisfaction. If you have questions, please address them with your physician during your visit.

Patient's/Guardian Signature

Date

