DERMATOLOGY MEDICAL HISTORY

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Name:_____ **Date of Birth:** ____/____/_____
Last First M.I.

Reason For Today's Visit_____

MEDICATION: List all medications. Include prescriptions, over-the-counter, vitamins, and herbals.

_____ _____ _____

_____ _____ _____

ALLERGIES: List any allergies to medications.

_____ _____ _____

Have you ever had dental anesthesia (Novocaine)? ☐ **YES** ☐ **NO** Bad reaction? ☐ **YES** ☐ **NO**

DISEASES/CONDITIONS: Check all that apply.

LUNGS
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Pacemaker
- ☐ Phlebitis

DISEASES OF THE:
- ☐ Ear, Nose, Mouth, Throat
- ☐ Eye
- ☐ Kidney/Bladder
- ☐ Thyroid

MENTAL HEALTH
- ☐ Stress, Anxiety
- ☐ Depression
- ☐ OCD

OTHER SYSTEMIC:
- ☐ Arthritis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Diabetes
- ☐ Fainting
- ☐ Fever/Chills/Night Sweats
- ☐ Seizures
- ☐ Weight Loss

☐ **NONE OF THE ABOVE CONDITIONS APPLY**

List any other diseases or conditions:_____

List any major surgical procedures:_____

Are you pregnant? (Women) ☐ **YES** ☐ **NO** If YES, Due Date: ____/____/____

SKIN: Check all that apply.

- ☐ Bleed Easily
- ☐ Develop Keloids After Surgery
- ☐ Problems Healing
- ☐ History of Skin Cancer
- ☐ Family History of Skin Cancer
- ☐ Recurrent Skin Infection
- ☐ History of Specific Skin Disease(s)_____
- ☐ Skin Rashes in Reaction to: ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Other:_____

SOCIAL: Check all that apply.

- ☐ Drink Alcohol If YES, _____ Drinks Per Day
- ☐ Smoke If YES, _____ Packs Per Day
- ☐ Use IV Drugs If YES, What and How Often: _____
- ☐ Been Exposed to HIV (AIDS)

Who is your Primary Care Physician?_____ Referred By:_____

What is your occupation?_____ Hobbies?_____

Patient or Responsible Party Signature:_____ **Date:**____/____/____

PATIENT INFORMATION

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Name:_____
Last *First* *M.I.*

Date of Birth: ____/____/_____ **SS#**_____ **Sex:** ☐ **Male** ☐ **Female**

CONTACT:

Mailing Address:_____
City *State* *Zip*

Home Phone: (_____)_____ **Work Phone: (_____)**_____

Cell Phone: (_____)_____

RESPONSIBLE PARTY (This section is needed <u>ONLY</u> if patient is under 18)

Name:_____
Last *First* *M.I.*

Mailing Address:_____
City *State* *Zip*

Home Phone: (_____)_____ **Work Phone: (_____)**_____

Relationship to Patient:_____

THE FOLLOWING SECTION IS VERY IMPORTANT

WE KINDLY ASK THAT YOU TAKE THE TIME TO FULLY COMPLETE IT

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

☐ **YES** ☐ **NO** If yes, please provide their names and phone numbers below:

Name:_____ **Name:**_____

Phone Number: (_____)_____ **Phone Number: (_____)**_____

Relationship: _____ **Relationship:**_____

May we leave personal medical information on your answering machine or voicemail?

☐ **YES** ☐ **NO**

****EMERGENCY CONTACT INFORMATION****

In case of emergency, who should be notified? _____

Phone: **(_____)**_____ **Relationship:** _____

Patient or Responsible Party Signature:_____ **Date:**_____

Joseph Bikowski, M.D., Associates

BIKOWSKI SKIN CARE CENTER

500 Chadwick Street
Sewickley, PA 15143

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I am a patient of Joseph Bikowski, M.D. I hereby acknowledge receipt of
Dr. Bikowski's updated Notice of Privacy Practices, effective September 20, 2013.

Patient Name [please print]: _____

Signature: _____

Date: _____/_____/_____

*************If patient is under 18*************

Parent or Legal Guardian Name [please print]: _____

Signature: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Date: _____/_____/_____