

Patient Name: _____ Patient Date of Birth: _____ Date: _____

Patient Social Security #: _____ Email: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone Number: _____

Insurance Subscriber (Primary)

Name: _____ Date of Birth: _____ Social Security #: _____

Relationship: _____

Insurance Subscriber (Secondary)

Name: _____ Date of Birth: _____ Social Security #: _____

Relationship: _____

Reason(s) for your visit:

	Concern	Location	Duration	Past Treatment	Current Treatment	What Makes It Better?	What Makes It Worse?
1							
2							
3							
4							
5							

Who is your Primary Care Physician?

Physician Name: _____

Clinic Name: _____

Preferred Pharmacy and Phone Number:

Regular: _____

Compounding: _____

CURRENT MEDICATIONS: Please tell us any medications (including vitamins or supplements) that you currently take.

	Medication / Vitamin	Strength	Dosage	Doctor	Reason for Medication
1					
2					
3					
4					
5					

ALLERGIES:

ALLERGY	REACTION
1	
2	
3	
4	

PATIENT SURGICAL HISTORY/COSMETIC SURGERY HISTORY

	Type of Surgery / Hospitalization	Date	Anesthesia Complications	Notes
1				
2				
3				
4				
5				

PAST MEDICAL HISTORY: (Example: High Blood Pressure, High Cholesterol)

1	5	9
2	6	10
3	7	11
4	8	12

FAMILY HISTORY:	No	Yes	Affected Family Members	Notes:
Adopted?	<input type="checkbox"/>	<input type="checkbox"/>		
Autoimmune Disorders (Like Lupus)?	<input type="checkbox"/>	<input type="checkbox"/>		
Breast Cancer?	<input type="checkbox"/>	<input type="checkbox"/>		
Colon Cancer?	<input type="checkbox"/>	<input type="checkbox"/>		
Prostate Cancer?	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Disease?	<input type="checkbox"/>	<input type="checkbox"/>		
Lung Disease?	<input type="checkbox"/>	<input type="checkbox"/>		
Non-Melanoma Skin Cancer?	<input type="checkbox"/>	<input type="checkbox"/>		
Melanoma Skin Cancer?	<input type="checkbox"/>	<input type="checkbox"/>		
Psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>		
Scarring Acne?	<input type="checkbox"/>	<input type="checkbox"/>		
Osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>		
Thyroid Disease?	<input type="checkbox"/>	<input type="checkbox"/>		
Other?				

SOCIAL HISTORY – PATIENT	No	Yes	Notes:
Are you currently employed? If yes, what is your job?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you married?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you drink alcohol? If so, how much and how often?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever abused IV drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any risk factors for infectious diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you or have you ever smoked tobacco? If so, how much and for how long?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use chewing tobacco? If so, how much and for how long?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use tanning beds? If so, how often?	<input type="checkbox"/>	<input type="checkbox"/>	
HORMONE REPLACEMENT ONLY:	No	Yes	Notes:
Are you sexually active?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you want to be sexually active?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you completed your family?	<input type="checkbox"/>	<input type="checkbox"/>	
Has your sex life suffered?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been able to orgasm?	<input type="checkbox"/>	<input type="checkbox"/>	

REVIEW OF SYSTEMS (CHECK ALL CURRENTLY ACTIVE SYMPTOMS)

SKIN:	No	Yes	Notes:
Do you form thick scars (keloids)?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your skin appear fragile or burn easy?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use sunblock daily?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have problems with healing?	<input type="checkbox"/>	<input type="checkbox"/>	

Do you have any nail changes?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any non-healing sores?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any rashes?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have acne?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any mole changes?	<input type="checkbox"/>	<input type="checkbox"/>	
ALLERGIC/IMMUNOLOGIC:	No	Yes	Notes:
Do you have skin allergies?	<input type="checkbox"/>	<input type="checkbox"/>	
CONSTITUTIONAL SYMPTOMS:	No	Yes	Notes:
Do you faint easily?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have unexpected weight change?	<input type="checkbox"/>	<input type="checkbox"/>	
EARS, NOSE, MOUTH, THROAT:	No	Yes	Notes:
New onset of persistent cough?	<input type="checkbox"/>	<input type="checkbox"/>	
ENDOCRINE:	No	Yes	Notes:
Do you have abnormal hair growth?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have cold or heat sensitivity?	<input type="checkbox"/>	<input type="checkbox"/>	
GASTROINTESTINAL:	No	Yes	Notes:
Abdominal Pain?	<input type="checkbox"/>	<input type="checkbox"/>	
Change in bowel habit?	<input type="checkbox"/>	<input type="checkbox"/>	
HEMATOLOGIC / LYMPHATIC:	No	Yes	Notes:
Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have lymph node swelling?	<input type="checkbox"/>	<input type="checkbox"/>	
MUSCULOSKELETAL:	No	Yes	Notes:
Do you have bone pain?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have muscle weakness?	<input type="checkbox"/>	<input type="checkbox"/>	
NEUROLOGICAL:	No	Yes	Notes:
New onset of headaches?	<input type="checkbox"/>	<input type="checkbox"/>	
RESPIRATORY:	No	Yes	Notes:
Worsening shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	
Peripheral Vascular:	No	Yes	Notes:
Do you have leg swelling?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have varicose veins?	<input type="checkbox"/>	<input type="checkbox"/>	

FEMALE ONLY HORMONE QUESTIONS	N/A	Never	Mild	Moderate	Severe
Irregular or heavy periods? Date of last period:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood changes/irritability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with focusing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory Problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Dryness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased libido?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sexual responsiveness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty to climax sexually?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss/thinning or texture changes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain? If yes, how much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FEMALE ONLY HORMONE QUESTIONS CONT...	N/A	Never	Mild	Moderate	Severe
Sleep problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wake up tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good energy during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last pap smear? Facility/Date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last pelvic ultrasound?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last mammogram? Facility/Date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last bone density test? Facility/Date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling all over the body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cold all the time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of uterine cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of ovarian cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MALE ONLY QUESTIONS	N/A	Never	Mild	Moderate	Severe
Wake up tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good energy during the day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of strength?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of muscle mass?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased libido?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impotence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain? If so, how much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aggressive behavior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testicular shrinkage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in breast tissue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last prostate exam? Where was it done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decline in general well being?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain/muscle aches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive sweating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased need for sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Declining mental ability/focus/concentration?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling you have passed your peak?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling burned out or hit rock bottom?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rapid hair loss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in beard growth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New migraine headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased morning erections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infrequent or absent ejaculations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No results from E.D. medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Birth Control Method	No	Yes	Notes
Menopause	<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy with removal of ovaries	<input type="checkbox"/>	<input type="checkbox"/>	
Hysterectomy only	<input type="checkbox"/>	<input type="checkbox"/>	
Oophorectomy - removal of ovaries	<input type="checkbox"/>	<input type="checkbox"/>	
Vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>	
Birth control pills	<input type="checkbox"/>	<input type="checkbox"/>	

HealthCARE Express®

Dermatology and Age Management

Persons Authorized to Receive Information:

Any information about appointments, treatment, and/or other information pertinent to my health that HealthCARE Express Dermatology & Age Management collects or receives about you may be disclosed to the following:

Name of Person/Relationship

Name of Person/Relationship

This request will remain in effect throughout treatment at HealthCARE Express Dermatology & Age Management and may repeatedly be released to the authorized parties listed above. You may revoke this authorization or change the recipient by requesting a new authorization form at any time.

Name of Patient

Signature of Patient/Date Signed

Office Representative

HealthCARE Express®

Dermatology and Age Management

HIPAA Acknowledgement Form

I hereby acknowledge that I was given a copy of the HealthCARE Express, LLP. Privacy Rules and regulations.

Patient Name _____

Patient DOB _____

Today's Date _____

Signature of Patient or Guarantor: _____

.....

Insured Patients:

This office is required to keep your signature on file authorizing us to file claims on your behalf and release information to your insurance company as necessary for the proper consideration of a claim.

Insurance is filed as a courtesy to the patient. We must have a valid copy of the insurance card. If the information given is incorrect or expired, this will cause a delay in processing. By signing below you authorize HealthCARE Express, LLP. to file claims on your behalf.

Patient names as appears on the insurance card: _____