HealthCARE Express®
Dermatology and Age Management

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?	☐	☐		
Autoimmune Disorders (Like Lupus)?	☐	☐		
Breast Cancer?	☐	☐		
Colon Cancer?	☐	☐		
Prostate Cancer?	☐	☐		
Heart Disease?	☐	☐		
Lung Disease?	☐	☐		
Non-Melanoma Skin Cancer?	☐	☐		
Melanoma Skin Cancer?	☐	☐		
Psoriasis?	☐	☐		
Scarring Acne?	☐	☐		
Osteoporosis?	☐	☐		
Diabetes?	☐	☐		
Thyroid Disease?	☐	☐		
Other?				

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

REVIEW OF SYSTEMS (CHECK ALL CURRENTLY ACTIVE SYMPTOMS)

SKIN:	No	Yes	Notes:
Do you form thick scars (keloids)?	☐	☐	
Does your skin appear fragile or burn easy?	☐	☐	
Do you use sunblock daily?	☐	☐	
Do you have problems with healing?	☐	☐	

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

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

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

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

Birth Control Method	No	Yes	Notes
Menopause	☐	☐	
Hysterectomy with removal of ovaries	☐	☐	
Hysterectomy only	☐	☐	
Oophorectomy - removal of ovaries	☐	☐	
Vasectomy	☐	☐	
Tubal ligation	☐	☐	
Birth control pills	☐	☐	

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: _____