

Dermatology Associates, PC
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Indianapolis, IN 46240
(317) 257-1484

Patient Acknowledgement Form

Our commitment to our patients is protecting their health information. This office is in compliance with the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**). The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient. These notices describe your rights as our patient and our obligations regarding the use and disclosure of your health information.

Please read all of the information that has been given to you carefully. It will help you to better understand the guidelines and policies of our office. Please sign at the bottom of this page that you have read and acknowledge this information.

If you have any questions regarding this information please ask one of our staff members to assist you.

To protect your private healthcare information, please indicate who we can leave your medical information with by answering these questions:

- **Leave a message at home?** Yes NO Not Applicable
- **Leave a message on your answering machine at home?**
 Yes NO Not Applicable
- **Discuss your medical condition with any member of your household?**
 Yes NO

If yes, whom: _____

signature

Witness Signature Patient

Patient Name (please print)

Date

DERMATOLOGY ASSOCIATES, PC

MEDICAL HISTORY FORM

Name _____ Date _____

Reason for today's visit _____

Has Dr. Campbell Johnson previously seen you as a patient? No Yes. If yes, when? _____

Referring Physician: _____ Primary Care Physician: _____ Referred: Yes NO

Do you have Prescription Coverage? Yes NO Pharmacy: _____ Phone: _____

DO YOU NOW, OR HAVE YOU EVER HAD DISEASES OR CONDITIONS:

PROBLEM	NO	YES	IF YES, PLEASE EXPLAIN:
EYE PROBLEMS			
EAR PROBLEMS			
LUNG PROBLEMS			
HEART PROBLEMS			
PACEMAKER/ARTIFICIAL HEART VALVES			
HIGH BLOOD PRESSURE			
DIABETES (SUGAR)			
KIDNEY PROBLEMS			
LIVER/GALLBLADDER PROBLEMS			
INTESTINAL PROBLEMS			
ARTHRITIS/JOINT PROBLEMS			
SEX ORGAN PROBLEMS			
SEIZURES/FAINTING SPELLS			
CANCER			
OTHER MEDICAL PROBLEMS			

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you ever had skin cancer? No Yes If yes, where _____ when? _____ type? _____
 Do you have a history of any specific skin disease? No Yes If yes, what? _____
 Have blood relatives had skin cancer? No Yes If yes, who? _____
 Have blood relatives had a history of any specific skin disease? No Yes If yes, what? _____

What is your occupation or school & grade? _____ Are you retired? _____

What are your hobbies? _____
 Do you drink alcohol? No Yes If yes, how many drinks per day? _____
 Have you had a problem with excessive drinking? No Yes If yes, when? _____
 Do you smoke cigarettes? No Yes If yes, how many packs per day? _____
 Do you have risk factors for AIDS? No Yes If yes, what? _____
 Do you bleed TOO easily? No Yes If yes, when? _____
 Have you had dental numbing medicine? No Yes If yes, any problems? _____
 Have you ever had a surgical procedure? No Yes If yes, what & year? _____
 Do you have artificial joints? No Yes If yes, where? _____
 Do you have problems with scars? No Yes If yes, where? _____
 Do you have problems with discoloration? No Yes If yes, where & when? _____

WOMEN: Are you pregnant? No Yes If yes, when are you due? _____
 WOMEN: Do you get yeast infections? No Yes If yes, when? _____

Patient's Name _____

List all of your medications. Include pills, creams, birth control pills, vitamins, aspirins, tylenol, suppositories, and any other prescription or non prescription products you are currently using.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List all of your medications. Including pills, creams, birth control pills, vitamins, aspirins, tylenol, suppositories, and any other prescription or non prescription products you have used in the last year but have now stopped.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ARE YOU ALLERGIC to or had **ANY PROBLEMS** with any **MEDICATION/PRODUCTS**? No, Yes.

If yes, what? _____

Annual update: Year, initials

05 ____ 06 ____ 07 ____ 08 ____ 09 ____ 10 ____ 11 ____

Initial Form Completed by:

- Patient _____
- Other _____

Reviewed by:

- Medical assistant _____ (Initials)
- Physician _____ (Initials)

Dermatology Associates, PC

Hair & Vein Removal • Sun Spot Removal • Restylane • Botox • Skin Care

Please answer yes or no to the following questions:

- YES NO
- Are you using any prescribed medications? List _____
- Are you using any Herbal medications? List _____
- Do you take oral anti-coagulant (blood thinning) medication? List _____
- Are you allergic to any cosmetic ingredients, medications or foods?
List _____
- Are you pregnant or trying to become pregnant?
- Do you use oral contraceptives?
- Do you use hormone replacement therapy?
- Do you smoke? How much? _____ How long? _____
- Do you spend a lot of time outdoors or use a tanning bed often?
- Do you have any tattoos or permanent makeup?

In addition to the above, please tell us which skin conditions concern you the most (Check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Brown spots (Hyperpigmentation) | <input type="checkbox"/> White spots (Hypopigmentation) |
| <input type="checkbox"/> Uneven skin tone | <input type="checkbox"/> Visible exposed blood vessels | <input type="checkbox"/> Hard bumps under skin |
| <input type="checkbox"/> Enlarged pores | <input type="checkbox"/> Clogged pores | <input type="checkbox"/> Blackheads/Whiteheads |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Excessive oiliness | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Upper lip lines | <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Scarring |
| <input type="checkbox"/> Sun Spots | <input type="checkbox"/> Dry patches | <input type="checkbox"/> Unwanted Hair |
| <input type="checkbox"/> Other: _____ | | |

What is your skin type: Dry Combination Oily Normal

How much water do you consume per day? _____

Please check the products you currently use and list the Brand Names of Cosmetic Products:

- | | | |
|--|--|---|
| <input type="checkbox"/> Cleanser _____ | <input type="checkbox"/> Soap _____ | <input type="checkbox"/> Toner _____ |
| <input type="checkbox"/> Moisturizer _____ | <input type="checkbox"/> Night Cream _____ | <input type="checkbox"/> Mask _____ |
| <input type="checkbox"/> Eye cream _____ | <input type="checkbox"/> Astringent _____ | <input type="checkbox"/> Glycolic Wash/Cleanser |
| <input type="checkbox"/> Scrub _____ | <input type="checkbox"/> Sunscreen _____ | <input type="checkbox"/> Salicylic Wash/Cleanser |
| <input type="checkbox"/> Vitamin A Cream | <input type="checkbox"/> Vitamin C Creams | <input type="checkbox"/> Alpha or Betahydroxy Cream |

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation?
Please list _____

Have you ever had any of the following wrinkle fillers or implants:

- Collagen Restylane Perlane Hylaform Juvaderm Silicone Radiance
- Sculptra Other: _____
- * If so then when was it done? _____ What area? _____
By whom? _____

Please check any health problems, past or present:

- | | | | | |
|--|---|--|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Skin cancer (Type: _____) | | |
| <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cystic Acne | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Collagen | <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Vasovagal Syncope | <input type="checkbox"/> PCOS | <input type="checkbox"/> Autoimmune (lupus, scleroderma) | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Other: _____ | | | | |

Do you have any of the following chronic skin disorders?

- | | | | |
|---|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Keloid Scarring |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Sun Blisters | <input type="checkbox"/> Herpes Simplex/Blisters |

Have you ever undergone any of the following treatments?

- Acid Peel Cosmetic Surgery Lasers Botox Accutane Microdermabrasion

When and where was it done? _____

Are you currently removing hair by any of the following methods?

- Waxing Tweezing "Nair" type products Electrolysis Laser Hair Removal
- * If so when was it done _____ what area _____ and what type of laser? _____

I certify that the above information is correct to the best of my knowledge.

Patient's Signature _____

Dermatology Associates offers a wide range of products and treatment plans for our patients.

Our goal is to help our patients Restore their Natural Beauty and Glow.

Check off any and all that apply if you are interested in more information.

Treatment for:

- Rough texture to your face
- Redness
- Dark spots
- Brown spots
- Dilated pores
- Acne scarring
- Age spots
- Uneven skin tone
- Facial rejuvenation
- Permanent make-up
- Broken blood vessels on the face
- Broken blood vessels on the legs
- Red lesions
- Unwanted hair
- Scars
- Fine lines and wrinkles present when the face is in motion, i.e. smiling, laughing, talking, etc.
- Fine lines and wrinkles present when the face is at complete rest
- Loss of volume on the dorsal hands
- Unwanted areas of fat:
 - Underneath the eyes
 - Underneath the chin
 - Abdominal area- upper or lower
 - Upper back
 - Back of the arms
 - Sides of the waist (love handles)
 - Inner thighs
 - Outer thighs (saddle bags)
- Cellulite
- Hair loss
- Sagging skin