

**Dermatology Associates, PC**  
**931 86<sup>th</sup> Street, Suite 104**  
**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.

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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)