Aesthetic Surgery & Dermatology
Adrienne Stewart, Doctor of Medicine
of Cherry Creek

Patient Information Form Date: _____

Name: _____ Preferred Name:_____
First MI Last

Sex M:__ F:___ Other:_____ _____ DOB:_____ AGE_____

Email:_____Needed for access to the patient portal.

Cell #:_____ _____Home Phone #:_____

*Can we leave a detailed message on voicemail? Yes: ____ No:_____

Address_____

_____
City State Zip Code

Mailing address _____ check if same as above

Circle Marital Status: Single, Married, Separated, Divorced, Widowed, Decline
Significant Other: _____

Circle Ethnicity: Hispanic/Latino, Not Hispanic/Latino, Other: _____, Decline

Circle Race: American Indian or Alaska Native White, Black, Asian, Decline

Reason for this visit: _____

Have you been seen in our office previously? No, Yes Last Visit:_____

How did you hear of our office? _____

Employer: _____ Phone: _____

Occupation: _____

Circle Status: Part-time, Full-time, Self-Employed, Retired, Active Military, Student, Unemployed

Person responsible for payment: _____ Relationship: _____

Phone: _____

*Emergency Contact Name: _____Relationship:_____

Phone: _____.

I do give my consent and permission to share and discuss my medical information, history, tests, and labs with _____. Phone: _____

Relationship: _____.

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PHARMACY If you do not have a regular pharmacy, please choose the most convenient (i.e. a location at which you regularly shop) for any prescription which may be sent during your upcoming visit.

Name, Address or Cross Streets: _____

_____

Phone #: _____ Mail Order: _____

CARE TEAM

Primary Care Provider: _____ Phone:_____

Another, Specialist Name:_____

Specialty:_____ Phone: _____

Patients 65+:

Advanced Directive: Do you have one of the following?

___Power of Attorney (Surrogate Decision Maker) ___Living Will (Advance Care Plan)

___None

Name/Relationship_____

Have you received a Pneumonia Vaccine? *No* *Yes*

PATIENT QUESTIONAIRE

Have you ever been diagnosed with ***Melanoma***? *No* *Yes* Locations:_____

When, Details:_____

Do you or have you used a **tanning** bed? *No,* *Yes,* Currently, Past:_____

Do you have a **history of blistering sunburn**? *No* *Yes* How Often _____

Do you wear **sunscreen**? *No* *Yes* What SPF_____ How often?_____

Do you have any **immediate family members with skin cancer**? No ___ Yes ____

Which family member(s) and what type of skin cancer, if known, i.e. Basal Cell Carcinoma, Squamous Cell Carcinoma, Malignant Melanoma, or uncertain?

_____

_____

_____

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Authorization and Release (Please READ AND INITIAL each line and sign at the bottom)

1. Initial_____ I hereby acknowledge receipt of Aesthetic Surgery & Dermatology's Notice of Privacy Practices.
2. Initial_____ Late/Cancellation/No Show policy: To better serve our patients, we ask that if you are going to be more than 10 minutes late, please call use to ensure that we can still work you into our schedule. If you need to cancel or reschedule an appointment, we ask that you call 24 hours prior to your appointment. Failure to cancel or reschedule for a surgery or procedure 24 hours or more prior to appointment, you will be charged.
3. Initial_____ I am responsible for payment in full at time of service unless previous arrangements have been made.
4. Initial_____ I hereby authorize the release of medical information to my insurance carrier that may be necessary to process my claim, and to any other facility or Doctor involved in my care.
5. Initial_____ I hereby authorize payment directly to Aesthetic Surgery & Dermatology for my medical expenses.
6. Initial_____ In the event it is necessary to refer this account to collections, I/we agree to pay all costs of collection including but not limited to reasonable attorney fees, court costs and interest permitted by law.
7. Initial_____ If my insurance company denies payment, I agree to be personally and fully responsible for any of the remaining balance. I authorize Aesthetic Surgery and Dermatology to charge my credit card I may have on file for these balances.

8. Initial_____ I authorize this facility to contact the patient, or authorized representative or guardian with any necessary medical information through telephone, fax or other communication.
9. Initial_____ I have read and understand the above information. I also verify that the information is correct.

I hereby verify above information above is accurate and complete.

X_____

Signature of Patient, Parent / Guardian, or Personal Representative

Relationship to Patient: _____ Date:_____

Have you ever been screened for **Hepatitis C?** Yes or No

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MEDICATIONS: Please list any/all medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication, including recreational). If None, write "None"

Medication:	Dose:	Frequency:	For What condition(s)?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: List all allergies, including latex, seasonal, medical, food, environmental. Include your reactions._____

_____

_____

Do you use tobacco products? *No, Never* *Former* *Yes* : how many packs / day?_____

Former Smoker: Quit date: _____ Years: _____ Packs/day:_____

Snuff: _____ Chew_____

Have you received a Flu Vaccine this past year? *No* *Yes*

Do you drink alcohol? *No* *Yes* How many drinks per day/month? _____

*In the past year have you had 5 or more drinks in a day for men? or 4 or more drinks in a day for women? Please Circle: *Never* *Once* *Twice* *Three Occasions* *Four or More* _____.

Substance Abuse? *Circle*: *Never, Former,* *Yes*, How Often: _____

Current Type: _____

*ALERTS: Check all that apply.

	Pregnancy or Planning a Pregnancy?		Cold Sores or History of HSV
	Currently Breast Feeding?		MRSA
	Adhesive Allergy		Hepatitis B
	Topical Antibiotic Ointment Allergy		Hepatitis C
	Lidocaine Allergy		HIV Positive
	Rapid Heartbeat with Epinephrine		West African Travel or Contact
	Artificial Heart Valve		Ebola Risk: Fever>100.4° F / 38.0° C
	Artificial Joints within last 2 years		Ebola Risk: Resided or Traveled to Country with wide-spread Ebola Transmission in last 21 days
	Defibrillator		Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage
	Pacemaker		Blood Thinners
	Premedication prior to procedures		Fainting with injections

Additional Alerts:

_____

_____

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Your Medical History Check and List all that Apply

__	Allergies or Hay Fever	__	Cancer or history of: Which/Where
__	Arthritis	__	History of positive blood transfusion(s)
__	Asthma	__	History of positive PPD or Tuberculosis, TB
__	Autoimmune Disorder		HIV / AIDS
__	Bleeding Disorders	__	Hives
__	Blood Clots	__	Immune suppression, including
__	Depression / Anxiety	__	transplant patient
__	Diabetes - Type 1 or Type 2?		Irregular menstruation of PCOS
__	Difficulty healing / keloids	__	Kidney Disease
__	Eczema	__	Liver Problems
__	Exposure to someone with Tuberculosis/TB	__	Lung Disorder, including COPD
__	Hearing loss	__	Migraines / Headaches
__	Heart attack / Stroke / CAD	__	Neurological Disorder, i.e. seizure
__	Heart disease, failure, or irregular heart	__	Psoriasis
__	Hepatitis Which type?	__	Thyroid Problems-Hyper/Hypo circle one
__	High Blood Pressure	__	
__	High Cholesterol		

List any other medical/skin problems: _____

_____

Past *Surgeries* (include date of surgery):

_____

_____

_____

_____

Please check if you have the following as related to your current situation – 1st of 2 pages

	Constitutional/Symptom		Psychiatric
___	fever or chills	___	anxiety
___	night sweats	___	depression
___	unintentional weight loss	___	mood swings/changes in mood
___	unintentional weight gain	___	suicidal thoughts or acts
___	fatigue	___	homicidal thoughts or acts
		___	other psychiatric

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	Skin/Integumentary		**Gastrointestinal (G.I.)**
___	new or changing moles	___	difficulty swallowing
___	changing skin lesion(s)	___	heartburn
___	rash(es)	___	nausea and/or vomiting
___	skin itching	___	constipation and/or diarrhea
___	skin or lip dryness	___	bloody stool
___	sun sensitivity	___	abdominal pain
___	hair changes		**Genitourinary (G.U.)**
___	nail changes	___	urinary frequency
___	problems with healing	___	pain with urination
___	problems with scarring (hypertrophic)	___	blood in urine
	Eyes	___	breast mass(es) or discharge
___	loss of vision		**G.U. Male Only**
___	blurred or distorted vision	___	penile discharge
___	vision haloes		**G.U. Female Only**
___	decreased or impaired night vision	___	vaginal bleeding or discharge
___	eye pain or soreness	___	pelvic pain [female only]
___	dry eyes	___	irregular menstruation
	ENT/Mouth		**Musculoskeletal**
___	dizziness	___	joint pain, swelling, redness
___	ringing in ears	___	muscle pain, aches or cramps
___	loss of hearing	___	neck stiffness
___	sinus congestion		**Endocrine**
___	runny nose/post nasal drip	___	heat or cold intolerance
___	nose bleeds	___	excessive thirst or hunger
___	sore throat	___	other thyroid problems
___	hoarseness or throat/mouth dryness	___	Hematologic/Lymphatic
___	dental health problems	___	problems with bruising
	Cardiovascular	___	problems with bleeding
___	chest pain	___	swollen lymph nodes
___	heart palpitations (irregular beating or heart skips a beat)		**Neurological**
		___	headaches, including migraines
___	cardiovascular other	___	numbness or tingling
		___	slurred speech
		___	weakness or paralysis
		___	fainting or blackouts
		___	seizures

<u>Return when finished.</u>