Follow-up Medical History

Appointment Date:_____

Patient Name: _____

Date of Birth: _____

PROVIDER: RE MW MH CC CM JH DS RH

INSURANCE: _____

PRIVATE PAY: ❑ DOUBLE COVERED: ❑

COPAY: $ DEDUCTIBLE: $ COINSURANCE: %

How are you paying today? ❑ Cash ❑ Check ❑ Card

(Only if applicable)

❑ Check here if you DO NOT want us to mail your biopsy results to you.

Are there changes in occupational or marital status from last appointment? ❑ No ❑ Yes:

Do you need a gown for your exam today? (For example, it's needed for a full body exam.) ❑ No ❑ Yes

Are there any new problems to be addressed today? ❑ No ❑ Yes:

Any change in medications since last visit? ❑ No ❑ Yes:

Any change in medical problems since last visit? ❑ No ❑ Yes:

Patient Summary Sheet reviewed? (See attached.) ❑ No ❑ Yes:

History of a Staph Infection or MRSA in the past? ❑ No ❑ Yes:

Please list medication allergies:

Problem #1

How long has the problem been present?

Where on your body are you having the problem?

Is the problem getting better or worse?

How severe is the problem?

What medications have been used to treat the problem?

What did the treatments do to the problem?

Problem #2

How long has the problem been present?

Where on your body are you having the problem?

Is the problem getting better or worse?

How severe is the problem?

What medications have been used to treat the problem?

What did the treatments do to the problem?

*** FOR OFFICE USE ONLY ***			
Excessive bleeding:.....	❑ No ❑ Yes	Easy bruising:.....	❑ No ❑ Yes
Allergy to Band-Aids:.....	❑ No ❑ Yes	Fever / chills:.....	❑ No ❑ Yes
Poor wound healing:.....	❑ No ❑ Yes	Feeling fatigued:.....	❑ No ❑ Yes
Sensitivity to sun:.....	❑ No ❑ Yes	Joint aches and pains.....	❑ No ❑ Yes
Keloid scar formation:.....	❑ No ❑ Yes	Trouble sleeping	❑ No ❑ Yes
Allergy to topical antibiotics:.....	❑ No ❑ Yes	History of weight loss.....	❑ No ❑ Yes

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PROVIDER SIGNATURE _____ DATE: _____