

**PATIENT INFORMATION**

***(Download and return in E-mail info@spencemd.com)***

**Date of Appointment:** Click or tap here to enter text.

**Patient's Name:** Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.

*First / MI / Last*

**Reason(s) for today’s visit:** Click or tap here to enter text.

**Age:** Click or tap here to enter text. **Date of Birth:** Click or tap here to enter text. **Marital Status: MSW DSep**

**Residence Address:** Click or tap here to enter text. **City:** Click or tap here to enter text. **State:** Click or tap here to enter text.

**Zip Code:** Click or tap here to enter text.

**Mailing or Alternate Address:** Click or tap here to enter text. **City:** Click or tap here to enter text. **State:** Click or tap here to enter text. **Zip Code:** Click or tap here to enter text.

**Home Phone:** Click or tap here to enter text. **Business Phone:** Click or tap here to enter text.

**Cell Phone:** Click or tap here to enter text. **Email Address:** Click or tap here to enter text.

**Height:** Click or tap here to enter text. **Weight:** Click or tap here to enter text.

**Sex: Male Female Race:** Click or tap here to enter text.

**Social Security Number:** Click or tap here to enter text. **Driver's License Number:** Click or tap here to enter text.

**May we contact you at work? Yes No Occupation:** Click or tap here to enter text. **Employer:** Click or tap here to enter text. **Business Address:** Click or tap here to enter text.

**Husband or (Father if child is a minor):** Click or tap here to enter text. Click or tap here to enter text.

*Name / Date of Birth*

Click or tap here to enter text. Click or tap here to enter text.

*Phone Number / Social Security Number*

**Wife or (Mother if child is a minor):** Click or tap here to enter text. Click or tap here to enter text.

*Name / Date of Birth*

Click or tap here to enter text. Click or tap here to enter text.

*Phone Number* / *Social Security Number*

**Emergency Contact:** Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text. *Name / Relationship / Phone Number*

**Primary Care Physician:** Click or tap here to enter text. **Phone:** Click or tap here to enter text.

**Have you or any members of your family been treated here before? Yes No Name:** Click or tap here to enter text.

**I heard about Hillcrest Dermatology and Plastic Surgery through:**

**Yellow Pages FriendPhysicianTVRadioPublicationWebsiteOther Please Name Publication:** Click or tap here to enter text. **Other:** Click or tap here to enter text.

**If referred by a friend or physician, please list their name so we may thank them:** Click or tap here to enter text.

***All professional services rendered are charged to the patient.***

**Pre-Operative History and Physical**

**Patient Name:** Click or tap here to enter text. **Date of Birth:** Click or tap here to enter text.

**Height:** Click or tap here to enter text. **Weight:** Click or tap here to enter text.

**Allergies:** (please include food, latex, adhesives, tape, oral or topical medications)



List previous surgeries and/or hospitalizations and dates: (including cosmetic services)



List all medications you are taking: (please, include non-prescription drugs, vitamins and minerals)



**Social History:** Alcohol (type and amount): Click or tap here to enter text.

Smoking (type and amount): Click or tap here to enter text.

**Family History:** Has any blood relative ever had the following

Breast Cancer  If so, relationship Click or tap here to enter text.

Testicular Cancer  If so, relationship Click or tap here to enter text.

Problems with Anesthesia  Bleeding or clotting disorder

**Medical History:** Do you currently or have you ever had the following (please check all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Heart Disease  Mitral Valve Prolaps  Hepatitis/Liver Disease  Glaucoma  Lupus  Anemia  Tuberculosis  Diabetes  Weight Changes  If so, lose or gain and amount  Click or tap here to enter text.lbs  Swollen Feet/Ankles  Skin Rash  Chronic Cough  Dry Eyes  Psoriasis |  | Anxiety  Sleep Apnea  Chest Pain  High Blood Pressure  Stomach Ulcer/Acid Reflux  Kidney Disease  Auto Immune Deficiency  Bleeding Tendency  Stroke  Malignant Hyperthermia  Seizures  Joint or Muscle Pain  Chronic Diarrhea  Wear Contact Lenses |  | Irregular Heart Rate  Cancer  Arthritis  Asthma  Thyroid Disease  Blood Clot  AIDS or HIV  Latex Allergies  Fainting  Jaundice  Swollen Lymph Nodes  Depression  Previous use of Accutane  Squamous Cell Carcinoma  Basal Cell Carcinoma  Actinic Keratosis  (Skin Pre-cancers)  Dysplastic/Atypical moles |
| Pain/Blood/Frequency with Urination  Eczema |
| **PLEASE EXPLAIN ALL CHECK MARKS:** | | |  |  |

**I verify that the above information is true and accurate to the best of my knowledge.**

**Patient Signature: Date:** Click or tap here to enter text.

*Purpose for today’s visit Click or tap here to enter text.*



*Please identify the areas you wish to discuss in the* ***future*** *with us*

# Areas for Enhancement

**Name:** Click or tap here to enter text. **Date:** Click or tap here to enter text.

Please mark the areas of **future** interest and the level of priority, using the following: 1-Low 2-Medium 3-High

**Body Contouring**

Arms  Thighs  Breasts  Abdomen  Buttocks

Other Click or tap here to enter text.

**Skin Care**

Acne  Small Broken Capillaries  Un-Even Skin Tone Skin Texture  Stretch Marks Longer Eye Lashes  Dry Skin  Oily Skin

Sun Damaged Face Sun Damaged Hands  Moles  Freckles

Skin Products  Dark/Age Spots  Large Pores  Sun Damaged Chest

Other Click or tap here to enter text.

**Facial Rejuvenation**

Wrinkles or Lines  Sagging or Drooping Skin  Ears  Face

Eye Lids  Brows  Skin Texture  Neck  Lips

Other Click or tap here to enter text.

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

PRINTED NAME: Click or tap here to enter text.

In connection with the medical services that I am receiving from Hillcrest Dermatology and Plastic Surgery, I hereby authorize disclosure of any and/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

1. Any third-party payor covering the medical services of the patient;
2. Other health care professionals and institutions involved in the delivery of health care to the patient;
3. The proponent of any legally sufficient subpoena, or in response to a court order;
4. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services:
5. Pharmacies; and
6. As otherwise required by law.

I further consent that photographs may be taken of me, or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my physician and under such conditions and at such times as may be approved by him.
2. The photographs shall be taken by my physician or by a photographer approved by my physician.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. This consent is valid from the date executed until revoked in writing by the patient. Please understand that revocation of the consent will not affect any action we took in reliance on consent before we received your revocation and we may decline to treat or continue treating you if you revoke this consent.

**I further understand that I have been given special access to the physician’s privacy notice and that I have the opportunity to place special restrictions upon the consent (see below). I may request a copy of the privacy notice at any time by contacting:**

**Contact person: Rayer Headley**

**Address: 130 Hillcrest Street, Orlando FL 32801**

**Telephone: 407-999-2585**

**Special restrictions:** 

**YOU MAY CONTACT ME AT: HOME WORK CELL**

**YOU MAY LEAVE A MESSAGE AT: HOME WORK CELL**

**CONTACT PHONE AND ADDRESS:** Click or tap here to enter text. Click or tap here to enter text.

**NAME:** Click or tap here to enter text. **RELATIONSHIP:** Click or tap here to enter text.

**CONTACT PHONE AND ADDRESS:** Click or tap here to enter text. Click or tap here to enter text.

**ADDITIONALLY, YOU HAVE MY PERMISSION TO DISCLOSE ANY OR ALL INFORMATION**

**TO:** Click or tap here to enter text.

**NAME:** Click or tap here to enter text. **RELATIONSHIP:** Click or tap here to enter text.

**CONTACT PHONE AND ADDRESS:** Click or tap here to enter text. Click or tap here to enter text.

**NAME:** Click or tap here to enter text. **RELATIONSHIP:** Click or tap here to enter text.

Signed:

Date:

Personal Representative (if applicable):

Witness:

**For office use only:**

Signed form received

Patient Refused

Emergency

Language barrier prevented acknowledgement or signature

Staff member’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidential Skin Health Questionnaire**

*The following information is necessary in determining how your skin will react during initial skin treatments or post-operative surgery. Please complete each of the following questions as your answers will determine the proper protocol to be used in the management of your skin care. If the question does not apply to you, please write “N/A” (not applicable).*

**Name:** Click or tap here to enter text. **Sex: Male Female**

**Email Address:** Click or tap here to enter text. **Date:** Click or tap here to enter text.

***Yes No***

**How often do you exercise?** Click or tap here to enter text.

**Are you under stress at this time?** Click or tap here to enter text.

**Have you ever had an allergic reaction to a food, drug, or skin care product?**

**Please explain.** Click or tap here to enter text.

**Have you or anyone in your family had Melanoma?** Click or tap here to enter text.

**Have you ever been to a dermatologist or plastic surgeon? If yes, for what procedure or treatment?** Click or tap here to enter text.

**Do you tan in a tanning bed or the sun? (Check all that apply)**

**Does your skin itch from certain products? (Cosmetics, aspirin, fabrics, etc.)**

**Explain:** Click or tap here to enter text.

**Do you have hypo-thyroidism or hyper-thyroidism? (Choose one)**

**Do you have any metal implants in your body (except fillings) such as a pacemaker, pins**

**in bones, or a copper IUD? If yes, explain.** Click or tap here to enter text.

**Have you ever had a herpes simplex infection in the area being treated?**

**Do you have an active herpes simplex infection in the area to be treated?**

**Have you ever had any other skin disease?** Click or tap here to enter text.

**Have you ever used Accutane? If yes, last date?** Click or tap here to enter text.

**Have you ever suffered from acne?**

**Do you form thick or raised scars from cuts or burns?**

**FEMALES ONLY:**

**Yes No**

**Do you have regular periods?**

**Post menopause?**

**Are you pregnant?**

**Do you have dark areas on your face that occurred during pregnancy?**

**MALE AND FEMALE**

**On a daily basis how much of the following liquids do you drink?**

**Coffee** Click or tap here to enter text. **Tea** Click or tap here to enter text. **Water** Click or tap here to enter text. **Soda** Click or tap here to enter text. **Juice** Click or tap here to enter text. **Other** Click or tap here to enter text.

**List any medications you apply topically:**



**Please specify “C”(current) or “P”(past) for any products you are currently using or have used in the past:**

|  |  |  |  |
| --- | --- | --- | --- |
| Hydroquinone | Eldoquin Forte | Melanex | Retin A/Tretinoine |
| Cleocin | Erythromycin | EmGel | Metro Gel |
| Benzoyl Peroxide | Hytone | Lidex | Zovirax |
| Tetracycline | Accutane | Alpha-Hydroxy Acids | Renova |
| Finacea | Aldara | 5-FU/Efudex | PDT |

**Other:**Click or tap here to enter text.

**What does your diet consist of?** Click or tap here to enter text.

**How does your skin react to sun? Without sunblock, when exposed to one hour of direct sun, do you (Choose one)**

Always Burn Burn First, then Tan Tan Always Tan/Never Burn

**Please check off any of the following that apply to your skin:**

|  |  |  |
| --- | --- | --- |
| Blackheads | Whiteheads | Enlarged Pores |
| Flakiness | Acne Scars | Deep Wrinkles |
| Fine Lines | Dark Spots | Dryness |
| Shiny Skin | Redness | Painful Pimples |

**Have you ever had any of the following?**

|  |  |  |
| --- | --- | --- |
| Glycolic Peels | Dermabrasion | Facials |
| TCA Peel | Obagi Blue Peel | Laser Resurfacing |
| Microdermabrasion | Jessner’s Solution Peel | Enzyme Peel |
| Other:  Click or tap here to enter text. | MicroNeedling | Intense Pulsed Light |

**How many times a day do you wash your face?**Click or tap here to enter text.

**What brand name skin care products are you using:**

**Cleanser:** Click or tap here to enter text.

**Toner:** Click or tap here to enter text.

**Moisturizer:**Click or tap here to enter text.

**Serums:** Click or tap here to enter text.

**Sunscreen (include SPF#):** Click or tap here to enter text.

**Eye Cream:** Click or tap here to enter text.

**Any other products?** Click or tap here to enter text.

**What specific concerns do you have about your skin and what changes would you like to see?**



Signature: Date: