Cahaba Dermatology
skin health center
Vlada Groysman, MD, FAAD

Medical, Patient, & Family History

Patient Name: _____ Birth Date: _____ Patient ID#_____

Referring Physician: _____ Primary Care Physician: _____

+++++ Make corrections on form and alert staff for any pre-filled information that is incorrect +++++

Patient Information

PLEASE PROVIDE FULL LEGAL NAME. PLEASE NOTE: PRESCRIPTIONS WILL BE CALLED IN UNDER YOUR LEGAL NAME

Full Mailing Address :				
Date of Birth:	Age:	Gender:		Email:
Home #:		Work #:		Cell #:
Occupation:		Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed		
Primary Language:			Race:	

Patient Medical Insurance

Primary Insurance (Complete or Review Insurance information)

Primary Insurance (if blank complete below):		
Insurance Address (see back of card):		
Insured ID#	Insured Group#	
Relationship to Policy Holder: ☐Self ☐Spouse ☐Child/Dependent ☐Other_____		
Complete Policy Holder Info below if **not** Self		
Name:	DOB:	SSN:

Secondary Insurance (Complete or Review Insurance information)

Secondary Insurance (if blank complete below):		
Insurance Address (see back of card):		
Insured ID#	Insured Group#	
Relationship to Policy Holder: ☐Self ☐Spouse ☐Child/Dependent ☐Other_____		
Complete Policy Holder Info below if **not** Self		
Name:	DOB:	SSN:

Appointment No-Show, Change & Cancellation Policy

Cahaba Dermatology strives to provide the highest level of patient care and respect patient's time in our office. Overscheduling is a practice in medicine to limit cost of no-show and cancellations, but leads to longer wait times. Our office does not overschedule our clinic and therefore will require **24 hrs** notice to change or cancel an appointment. Patients arriving more than 30 min after appointment start time may not be admitted to clinic and considered no-show. This policy allows our office to function with efficiency and provide the best care to all of our patients.

Following conditions will result in a $35 fee charged to patient account. Fee will be $100 for surgery appointments, $250 for vulvar clinic appointments:

- Patient fails to show for an appointment
- Patient arrives more than 30 min late and not admitted to clinic
- Patient cancels or changes appointment with less than 24-hrs notice and appointment slot cannot be filled

Please Initial to communicate acceptance of this policy Patient Initials _____

Pharmacy Information

Provide as much information as possible to ensure prescriptions are sent to correct pharmacy

Pharmacy Name: _____

Pharmacy Address/Location: _____

Phone number: _____ Fax number: _____

Reason for Today's Visit

To provide our patients with excellent care we request you limit visit concerns to one chief complaint. Alert staff immediately if you need to have records sent to our office from another physician.

Cosmetic consults will require a separate cosmetic consult appointment.

Concern: _____ Location: _____

Prior Treatments: _____ Complications: _____

Additional Information: _____

_____

_____

_____

Current Medications

Medication Name _____ Medication Name_____

Medication Name _____ Medication Name_____

Medication Name _____ Medication Name_____

Do you have any medication allergies? □ yes □ no If yes List_____

Past Medical History

Latex Allergy	□ yes	□ no	Bleeding Disorders	□ yes	□ no	Poor Wound Healing	□ yes	□ no
Lupus	□ yes	□ no	Adhesive Tape Allergy	□ yes	□ no	Heart Disease	□ yes	□ no
Arthritis	□ yes	□ no	Anticoagulant Treatment	□ yes	□ no	Kidney Disease	□ yes	□ no
Psoriasis	□ yes	□ no	Bacitracin Allergy	□ yes	□ no	Thyroid Disease	□ yes	□ no
Hepatitis	□ yes	□ no	Artificial Heart Valves	□ yes	□ no	Hypertension	□ yes	□ no
MRSA	□ yes	□ no	Pacemaker / Defibrillator	□ yes	□ no	High Cholesterol	□ yes	□ no
Diabetes	□ yes	□ no	Mitral Valve Prolapse	□ yes	□ no	Pre-Dental Antibiotics	□ yes	□ no
Eczema	□ yes	□ no	Immunosuppressed	□ yes	□ no	Epinephrine Allergy	□ yes	□ no
Asthma	□ yes	□ no	Organ Transplant	□ yes	□ no	Neosporin Allergy	□ yes	□ no
HIV Positive	□ yes	□ no	CCL Chronic Leukemia	□ yes	□ no	Artificial Joint	□ yes	□ no
HSV / Cold Sore	□ yes	□ no	Memory Problems	□ yes	□ no	Pre-op Antibiotics	□ yes	□ no
Hay Fever	□ yes	□ no	Fainting / Syncope	□ yes	□ no	Abnormal Scars	□ yes	□ no
			Local Anesthetic Allergy	□ yes	□ no			

Skin Cancer History

Do you have a history of melanoma? □ yes □ no

Do you have a history of other skin cancer(s)? □ yes □ no If so, what types?_____

Do you have a **family history** melanoma? □ yes □ no If so, list relation _____

Do you have a **family history** of other cancer(s)? □ yes □ no If so, what types?_____

Social History

Do you use tobacco? □ yes □ no If yes, list all types:_____

Recreational Drug Use □ Yes □ No If Yes, Specify:_____

Alcohol consumption? □ None □ Socially □ Moderate □ Heavy

Do you use sunscreen? □ None □ Daily □ Occasionally □ Never

Tanning Bed Usage? □ Never □ Currently Using □ Previously Used

Additional Symptoms

Easy Bruising □ yes □ no Shortness of breath □ yes □ no Fever □ yes □ no

Weight Loss □ yes □ no Nausea/Vomiting □ yes □ no Anxiety □ yes □ no

Headache(s) □ yes □ no Abdominal Pain □ yes □ no Fatigue □ yes □ no

Blood Clots □ yes □ no Swollen lymph nodes □ yes □ no Joint Pain □ yes □ no

Eye Irritation □ yes □ no Constipation □ yes □ no Rash/Itch □ yes □ no

Chronic Cough □ yes □ no

Women' s Only History

Are you pregnant? □ yes □ no Are you breastfeeding? □ yes □ no

Are you on birth control? □ yes □ no

Do you have regular menstrual cycles? □ yes □ no

Skin Care Regimen

Tell us about your skincare regimen...

AM Routine:

Cleanser: _____

Prescription Products: _____

Facial Day Cream/Serum: _____

Sunscreen: _____

Other: _____

PM Routine:

Cleanser: _____

Prescription Products: _____

Facial Night Cream/Serum: _____

Other: _____

Let us know if you're interested...

Spa/Skin Care	Cosmetic Dermatology	Laser & Energy
☐ Acne Blue Light	☐ Broken Blood Vessels	☐ GentleMax® Laser Hair Removal
☐ Facial / HydraFacial MD®	☐ Botox® Injectable Cosmetic	☐ PicoWay® Laser Tattoo Removal
☐ Sunscreen Advice	☐ Injectable Filler Cosmetics	☐ miraDry® Problem Sweat Treatment
☐ Chemical Peels	☐ Age Spots/Brown Spots/Rosacea	☐ $C0^2$ Laser Rejuvenation
☐ Latisse	☐ Vein Treatment	☐ Photo facial/IPL Laser Treatment
☐ MicroNeedling	☐ Sculptra® Cosmetics	☐ Ematrix® Sublative Resurfacing
☐ Platelet Rich Plasma	☐ Cosmetic Consultation	☐ Photo facial/IPL Laser Treatment
☐ Skin Care Products	☐ Excessive Sweating	
Other Spa: _____	Other Cosmetic:_____	Other Laser: _____

How did you hear about our office? _____

Primary Care Physician: _____

What would you like to Improve?_____

_____

_____