

Patient Name: _____ Chart #: _____

General Consent to Examine and Provide Treatment

The signature below gives the medical providers at Yellowstone Dermatology permission to perform an examination on the above named patient. It further authorizes prescription treatment be recommended.

If patient is a minor, the parent/guardian agrees to examination and prescription of treatment in the absence of the parent/guardian.

I agree to physical examination and treatment recommendation:

Signed _____ (patient if over 18)

Or

Signed _____ (parent / guardian)

Date _____

Medical History

Have you or your family ever had any of the problems listed below? (If so, check box.)

	<i>You</i>	<i>Currently under treatment</i>	<i>Parent</i>	<i>Family</i>		<i>You</i>	<i>Currently under treatment</i>	<i>Parent</i>	<i>Family</i>
Asthma					Heart				
Hay fever					Lung				
Eczema					Kidney				
Hives					Bladder				
Poor healing					Bleeding disorder				
Epilepsy					Stomach				
Thyroid					Bowel				
Stroke					Diabetes				
Fainting spells					High Blood Pressure				
Lupus type disease					Melanoma or bad moles				
Headaches					Cancer (list type)				
Muscle or joint pain (arthritis)					Other Skin Problem (list)				

List *all* prescriptions, non-prescriptions, herbals, or vitamins you have taken in the last six months:

List all **ALLERGIES** to drugs, anesthetics, foods, clothing, jewelry chemicals, plants or insects:

Give approximate year and cause for **hospitalizations**:

Marital Status: Married _____ Single _____ **Your Occupation** _____

Do you smoke: <1 pack per day _____ >1 pack per day _____ quit over 1 year ago _____ NEVER _____

Do you drink alcohol: >2 drinks a day _____ <2 drinks per day _____ Occasionally _____ NEVER _____

Do you or have you ever used recreational drugs? Yes _____ No _____ Which ones? _____

Highest level of education completed: Grade _____ High School _____ College Yr. _____ Post grad. _____

Reviewed by MD: _____ **Date:** _____