MATHIESEN MEMORIAL HEALTH CLINIC

"Close to home…far from ordinary"

DERMATOLOGY MEDICAL QUESTIONNAIRE

Date:_____

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____ Date of Birth:_____/_____/_____

Phone number: _____ Social Security # (SSN): _____

Mailing Address: _____

Emergency Contact: _____ Relationship: _____ Phone Number:_____

If minor, guardian name: _____

PAST MEDICAL HISTORY (please check all that apply):

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hyperplasia
- ☐ Cerebrovascular Accident
- ☐ COPD
- ☐ Coronary Arteriosclerosis
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus
- ☐ Disease Caused by Covid-19
- ☐ Elevated Blood Pressure
- ☐ End State Renal Disease
- ☐ Epilepsy
- ☐ GERD
- ☐ H/O Hypertension
- ☐ Hearing Loss
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Liver Disease
- ☐ Leukemia
- ☐ Malignant Tumor of Breast
- ☐ Malignant Tumor of Colon
- ☐ Malignant Tumor of Lung
- ☐ Malignant Lymphoma
- ☐ Malignant Tumor of Prostate
- ☐ Radiation Therapy
- ☐ Transplantation of Bone Marrow
- ☐ Other: _____
- ☐ Other: _____

PAST SURGICAL HISTORY (please check all that apply):

- ☐ Abdominoperineal Resection
- ☐ Appendectomy
- ☐ Bilateral Mastectomy
- ☐ Bilateral Replacement of Knee Joints
- ☐ Biopsy of Breast
- ☐ Biopsy of Prostate
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Colostomy
- ☐ Coronary Artery Bypass Graft
- ☐ Entire Transplanted Kidney
- ☐ Excision of Basal Cell Carcinoma
- ☐ Excision of Melanoma
- ☐ Excision of Squamous Cell Carcinoma
- ☐ Hysterectomy
- ☐ Kidney Biopsy
- ☐ Liver Excision
- ☐ Low Anterior Resection of Rectum
- ☐ Lumpectomy of Left Breast
- ☐ Lumpectomy of Right Breast
- ☐ Mastectomy of Left Breast
- ☐ Mastectomy of Right Breast
- ☐ Mechanical Heart Valve Replacement
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Percutaneous Extraction of Kidney Stone with Fragmentation
- ☐ Percutaneous Transluminal Coronary Angioplasty
- ☐ Portosystemic Shunt Operation
- ☐ Prostatectomy
- ☐ Prosthetic Arthroplasty of Bilateral Hips
- ☐ Splenectomy
- ☐ Surgical Biopsy of Skin
- ☐ Tissue Graft Heart Valve Replacement
- ☐ Total Cystectomy
- ☐ Total Nephrectomy
- ☐ Total Orchidectomy
- ☐ Total Replacement of (Left, Right) Hip Joint
- ☐ Total Replacement of (Left, Right) Knee
- ☐ Transplant of Heart
- ☐ Transplant of Liver
- ☐ Transurethral Prostatectomy
- ☐ Tubal Ligation
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ None

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SKIN DISEASE HISTORY (please check all that apply):

☐ Acne	☐ Basal Cell Carcinoma of Skin	☐ Hay Fever / Allergies	☐ Squamous Cell Carcinoma
☐ Actinic Keratoses	☐ Contact Dermatitis Poison Ivy	☐ Malignant Melanoma	☐ Sunburn of Second Degree
☐ Asteatosis Cutis	☐ Dysplastic Nevus of Skin	☐ Pruritus of Scalp	☐ Other: _____
☐ Asthma	☐ Eczema	☐ Psoriasis	☐ Other: _____

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Medications (please list all current medications): _____

_____

_____

Medication Allergies: _____

_____

SOCIAL HISTORY (please check all that apply):

Do you smoke? ☐ Currently ☐ Past ☐ Never Total number of years:_____ Date Quit: _____

Cigarettes per day: _____ If you do smoke, are you interested in quitting? ☐ Yes ☐ No

Do you drink alcohol? ☐ No ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Family Medical History (only first degree relative): _____

_____

_____

Preferred Pharmacy Name: _____

Pharmacy Phone#: _____

Pharmacy City or Zip code: _____

REVIEW OF SYSTEMS (are you currently experiencing any of the following?)

Abdominal Pain	☐ Yes ☐ No	Keloid	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Muscle Weakness	☐ Yes ☐ No
Bloody Stool	☐ Yes ☐ No	Neck Stiffness	☐ Yes ☐ No
Bloody Urine	☐ Yes ☐ No	Night Sweats	☐ Yes ☐ No
Blurry Vision	☐ Yes ☐ No	Problems with Bleeding	☐ Yes ☐ No

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CONTINUED (are you currently experiencing any of the following?)

Chest Pain	☐ Yes ☐ No	Problems with Healing	☐ Yes ☐ No
Cough	☐ Yes ☐ No	Rash	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Fever or Chills	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Hay Fever	☐ Yes ☐ No	Sore Throat	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Immunosuppression	☐ Yes ☐ No	Unintentional Weight Loss	☐ Yes ☐ No
Joint Aches	☐ Yes ☐ No	Wheezing	☐ Yes ☐ No

Other symptoms: _____

ALERTS (please check all that apply):

☐ Allergy to Adhesive
☐ Allergy to Lidocaine
☐ Allergy to Topical Antibiotics
☐ Alzheimer's
☐ Artificial Heart Valve
☐ Artificial Joint Replacement
☐ Blood Thinners
☐ Defibrillator
☐ Dementia
☐ Hepatitis C
☐ HIV+
☐ MRSA
☐ Pacemaker
☐ Pregnant or Trying to become Pregnant
☐ Rapid heartbeat with epinephrine
☐ Require Antibiotics prior to a surgical procedure

Signature of Patient/Guardian: _____ Date:_____/_____/_____

Printed Name: _____

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CONSENT TO TREAT

I, the undersigned, am requesting health care services from the personnel at Mathiesen Memorial Health Clinic. I consent to exams, tests, immunizations, and treatment deemed necessary for my health. I hereby authorize the release of any information, including diagnosis of medical condition, for the purpose of payment by my insurance carrier. I affirm that the statements are true and correct to the best of my knowledge. I authorize the release of any information required by my insurance company to process claims. I further authorize assignment of benefits directly to Mathiesen Memorial Health Clinic. I understand that in the event the insurance information is not complete and correct, or if my insurance fails to make payment, I will be financially responsible for services rendered.

_____ ____/____/____

Printed Name Date of Birth

_____ ____/____/____

Signature of Patient/Parent/Guardian Date

Cancellations: If you need to reschedule, please call at least 24 hours in advance. Two consecutive no shows, or three in six months, can be grounds for discharge from our practice. Phone number 209-984-4820.

Medication Refill Policy: If you need a medication refill, please call your pharmacy to request and allow up to 5 business days to process. Please call the office to request any controlled substance refills and allow 5 business days to process. 209-984-4820.

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NOTICE OF PRIVACY PRACTICE

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Mathiesen Memorial Health Clinic (MMHC). Our Notice of Privacy Practice provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practice is subject to change. If we change our notice, you may obtain a copy of the revised notice by asking for one at the clinic or contacting our Privacy Officer at 209-984-4827.

If you have any questions about our Notice of Privacy Practice, please contact:

Privacy Officer
P.O. Box 535
Jamestown, Ca 95327
Phone: 209-984-4827

I acknowledge receipt of the Notice of Privacy Practices of Mathiesen Memorial Health Clinic.

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Signature: _____ Date: _____/_____/_____

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PATIENT AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

Do you give our office permission to discuss your medical and/or financial information with a person(s)?

☒ Yes ☐ No (If yes, please provide additional information below)

Name	Relationship	Phone Number

Please select authorized clinics:	Information authorized to discuss:
☐ Primary Care, Dermatology, Walk-In Clinic, and Dental ☐ Acupuncture, Red Feather Clinic, and Behavioral Health ☐ Other- Please Specify:	☐ Appointment Scheduling ☐ Treatment Details ☐ Lab and Test Results ☐ Insurance and Billing Information ☐ All Medical and Financial Information

This authorization will expire six months from the date signed, unless an alternate expiration date is noted here: _____

Name	Relationship	Phone Number

Please select authorized clinics:	Information authorized to discuss:
☐ Primary Care, Dermatology, Walk-In Clinic, and Dental ☐ Acupuncture, Red Feather Clinic, and Behavioral Health ☐ Other- Please Specify:	☐ Appointment Scheduling ☐ Treatment Details ☐ Lab and Test Results ☐ Insurance and Billing Information ☐ All Medical and Financial Information

This authorization will expire six months from the date signed, unless an alternate expiration date is noted here: _____

May we leave personal medical information on your answering machine, voicemail, email, or text message: ☐ Yes ☒ No

Patient Name: _____ Date of Birth:

Patient Signature: _____ Date:

Inability to obtain acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why it was not obtained. Patient reason for refusing or inability to sign acknowledgement:

_____

Staff Use- Clinic accepting Patient Authorization form:

☐ Primary Care
☐ Dental Clinic
☐ Walk-In Clinic
☐ Red Feather Clinic
☐ Wellness Center
☐ Acupuncture

Patient Label

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Missed Appointment Policy

Patient Name: _____ Date of Birth:

Thank you for choosing Mathiesen Memorial Health Clinic (MMHC) as your health care provider. To ensure the highest quality of care for you and all our patients, we ask that you adhere to our guidelines concerning missed appointments. MMHC provides appointment reminders as a courtesy, but we kindly ask that you take responsibility for keeping or canceling it as needed. We require at least 24-hour notice to cancel or reschedule your appointment. This allows us to offer your cancelled appointment slot to another patient in need of care.

While MMHC strives to minimize missed appointments, we will allow up to three missed appointments in a six-month period. An appointment is considered missed under any of the following circumstances:

- Patient fails to show up to a scheduled appointment.
- Patient provides fewer than 24 hours' notice to cancel or reschedule an appointment.
- Patient who arrives more than 10 minutes past their scheduled appointment time.
  **For dermatology and same-day appointments, the grace period is reduced to 5 minutes*.
- Wellness Center:
  - New patient – grace period is 15 minutes
  - Established patients – grace period is 30 minutes

Patients who miss three of more consecutive appointments within a rolling six-month period may be dismissed from care at the clinic's discretion.

_____ _____

Signature Date

_____

Printed Name

Relationship to Patient (if applicable): _____