Group Health
TriHealth Physician Partners

Group Health Dermatology Information

Today's Date:_____ Patient Name: _____ Date of Birth: _____

Referring Doctor: _____ What is your *MAIN* skin problem? _____

- What treatments have you used for this problem? _____

- Are there other skin problems you would like addressed at some point? _____
(Due to scheduling constraints, please note that additional visits may be necessary to address multiple problems)

- Have you had any of the following? (If yes, please circle and provide the location on body involved):

No / Yes → Skin cancer: ***Basal cell*** **_____** ***Squamous Cell*** **_____** ***Melanoma*** **_____**

No / Yes → Precancer: ***Actinic keratosis*** **_____** ***Precancerous/dysplastic mole*** **_____**

No / Yes → Other: ***Seasonal Allergies/Hayfever Food Allergies Eczema Asthma Psoriasis***

No / Yes → Medication allergies? (If yes, please specify - attach list if necessary) _____

_____

No / Yes → Medical Problems such as: ***Hypertension Diabetes High cholesterol Depression***

No / Yes → Tobacco use (how much): _____ No / Yes → Alcohol use (#drinks/week): _____

- Has a FAMILY member had: (If yes, please circle) No / Yes → ***Skin Cancer Melanoma Precancerous moles Lymphoma Environmental Allergies Eczema Asthma Psoriasis Severe Acne***

- Please list current medications (attach list if necessary): _____

_____

- Please list other medical problems, cancer, surgery or serious injury: _____

_____

- Your Occupation (and location): _____ Employer: _____ Live alone: No / Yes

CONSENT TO TREAT

I hereby authorize the physicians of Group Health to treat me, or my child/dependant. I understand that this treatment may include medication, tests, medical procedures and/or surgery. I understand that serious side effects occasionally occur as a result of medical and/or surgical treatment, and I understand that I should discuss with my health care provider any questions or concerns I have relating to my treatment. I understand that side effects which may occur as a result of procedures and/or surgery include discomfort, bleeding, infection, discoloration, scarring. I understand that my condition may not improve, or may even become worse, as a result of my treatment. I understand if more serious or invasive surgical treatment is recommended, I may refuse such care. I understand that health insurance, Medicare or other third party payers do not always pay for treatment/tests/procedures/surgery, and I agree that I (and/or the responsible person signing for me) will be responsible for the payment of any medical bills which are not covered by a third party.

_____ _____ _____ _____

Patient (or Parent/Guardian) signature Date Reviewed by: Nurse/MD initial Date