**BLUEGRASS DERMATOLOGY**

**Patient Registration Form**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Chart Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DEMOGRAPHIC INFORMATION**

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| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. / Suite: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**(REQUIRED FOR PATIENT PORTAL ACCESS)**  Home Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Preferred Number: [ ]Home [ ]Cell Can we leave a detailed Message: [ ]Yes [ ] No Method for reminders? [ ] Phone call [ ] Text [ ] E-mail [ ] All Three  Race: [ ] Caucasian [ ] African American [ ] Hispanic / Latino [ ] Asian [ ] American Indian [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Ethnicity: [ ] Hispanic [ ] Non-Hispanic Gender: [ ] Female [ ] Male Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed  Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**RESPONSIBLE PARTY BILLING INFORMATION** Relationship to Patient:[ ] Self [ ] Parent [ ] Guardian [ ] POA [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

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| Primary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am responsible for any charges deemed not medically necessary by my insurance company or otherwise not covered by my insurance company, including, but not limited to co-pays, deductibles and co-insurance payments.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan with which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of CASH, CHECK, VISA, DISCOVER, AMERICAN EXPRESS, MASTERCARD, DEBIT CARDS, MONEY ORDERS, and CASHIERS CHECKS. We also participate with Care Credit Financing. All balances due that do not get paid within the first 30 days are subject to finances which will accrue interest monthly.

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| **PHARMACY AND PRIMARY CARE PROVIDER (**Per Medicare and most insurances, you are required to list a primary care provider [PCP])    Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PATIENT Signature (or Parent/Guardian or POA):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**BLUEGRASS DERMATOLOGY**

**Patient Medical History Form**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Chart Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you referred here by another physician for a specific issue? \_\_\_Yes \_\_\_No

If Yes: Physician’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY** (circle all that apply) [ ] I do not have any medical history problems and/or conditions

Anxiety

Asthma

Bleeding Problems

Blood Clots

Cancer \_\_\_\_\_\_\_\_\_\_\_\_

Depression

Diabetes

Heart Disease

Hepatitis

High Blood Pressure

HIV / AIDS

Inflammatory Bowel Disease

Kidney Disease

Liver Disease

Migraines/Headaches

Seizures

Stroke

Thyroid Disorders

Tuberculosis

Tumors \_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY** (circle all that apply) [ ] I do not have any past surgical history

Skin Cancers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart / Lung Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Joint Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Liver / Kidney Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin Biopsy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prostate or Testicular \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brain or Spine Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stomach/Intestine/Colon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast or Gynecological \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Cancer Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SKIN MEDICAL HISTORY** (circle all that apply) [ ] I do not have any skin medical history problems and/or conditions

Basal Cell Carcinoma

Melanoma

Skin Cancer (unknown type)

Squamous Cell Carcinoma

Acne

Actinic Keratoses

Allergies

Atypical or abnormal moles

Blistering Sunburns

Eczema

Flaky or Itchy Scalp

Poison Ivy

Psoriasis

Skin Infections

Tanning Bed Use

**MEDICATION INFORMATION** [ ] I am not currently taking any medications

(List all medication you are currently taking and include all over-the-counter medications, herbals, vitamins, and minerals)

It is important you fill in ALL of the fields for each medication

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication(s) Name**  (What is the name of the medication?) | **Strength Unit**  (Strength of medication) | **Route**  (How you take it? ie oral, injection, under tongue, etc) | **Dose**  (How many taken?) | **Dose Form**  (ie tablet, capsule,liquid, gel, etc) | **Frequency**  (How often is medication taken?) | **Indication** (What medical condition does it treat? |
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| **PATIENT Signature (or Parent/Guardian or POA):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**BLUEGRASS DERMATOLOGY**

**Patient Medication/Allergy History Form**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient Birth Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Chart Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- |
| **Medication(s) Name**  (What is the name of the medication?) | **Strength Unit**  (Strength of medication) | **Route**  (How you take it? ie oral, injection, under tongue, etc) | **Dose**  (How many taken?) | **Dose Form**  (ie tablet, capsule,liquid, gel, etc) | **Frequency**  (How often is medication taken?) | **Indication** (What medical condition does it treat? |
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**ALLERGY INFORMATION** [ ] I do not have any allergies to any medications

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| --- | --- | --- | --- | --- | --- | --- |
| **Medication** | | | | **Allergic Reaction** | | |
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| Do you have an allergy to Latex Products? | 🞏 No | 🞏 Yes | Do you have an allergy to Adhesives? | | 🞏 No | 🞏 Yes |
| Do you have an allergy to Lidocaine? | 🞏 No | 🞏 Yes | Do you have an allergy to Topical Antibiotic Ointments? | | 🞏 No | 🞏 Yes |

**SOCIAL HISTORY** (Please answer **ALL** of the following questions)

[ ] Never smoker and/or tobacco user [ ] Former smoker and/or tobacco user [ ] Current smoker and/or tobacco user

[ ] I do not drink alcohol [ ] I drink alcohol

[ ] I have had flu vaccine current / past flu season [ ] I have not had flu vaccine [ ] I do not take flu vaccine [ ] I am allergic to the flu vaccine

[ ] I have had pneumonia vaccine [ ] I have not had pneumonia vaccine [ ] I do not take pneumonia vaccine [ ] I am allergic to the pneumonia vaccine

**Surrogate Decision Maker** (i.e. Living Will, POA, or family member / friend who can help you in medical emergencies)

[ ] I have a surrogate decision maker [ ] I do not have a surrogate decision maker [ ] I have a living will [ ] I have a POA

If you have a surrogate decision maker, who is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY** (circle all that apply) [ ] I do not have a family history of any medical conditions

**Please do not include yourself and/or spouse and only list family member(s) who had the medical condition**

Melanoma (family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Other Skin Cancers [unknown type]

(family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Cancer (family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Diabetes (family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Eczema or Psoriasis (family member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Other Pertinent Family History\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PATIENT Signature (or Parent/Guardian or POA):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**BLUEGRASS DERMATOLOGY**

**Patient Review of Systems Questionnaire Form**

**Are you currently experiencing any of the following? (Please mark Yes or No for the following):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SYMPTOMS** |  |  |  | **SYMPTOMS** |  |  |
| Abdominal Pain | 🞏 No | 🞏 Yes |  | Rash | 🞏 No | 🞏 Yes |
| Blurry Vision | 🞏 No | 🞏 Yes |  | Problems with Bleeding | 🞏 No | 🞏 Yes |
| Chapped Lips | 🞏 No | 🞏 Yes |  | Problems with Scarring/Healing | 🞏 No | 🞏 Yes |
| Depression | 🞏 No | 🞏 Yes |  | Changing Mole | 🞏 No | 🞏 Yes |
| Dry Skin | 🞏 No | 🞏 Yes |  | Thyroid Problems | 🞏 No | 🞏 Yes |
| Headaches | 🞏 No | 🞏 Yes |  | Sore Throat | 🞏 No | 🞏 Yes |
| Joint Pain | 🞏 No | 🞏 Yes |  | Muscle Weakness | 🞏 No | 🞏 Yes |
| Swollen Lymph Nodes | 🞏 No | 🞏 Yes |  | Night Sweats | 🞏 No | 🞏 Yes |
| Fever and Chills | 🞏 No | 🞏 Yes |  | Seizures | 🞏 No | 🞏 Yes |
| Cough | 🞏 No | 🞏 Yes |  | Heartburn | 🞏 No | 🞏 Yes |
| Nausea or Vomiting | 🞏 No | 🞏 Yes |  | Wheezing | 🞏 No | 🞏 Yes |
| Unintentional Weight Loss | 🞏 No | 🞏 Yes |  |

**Please mark Yes or No for the following:**

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| --- | --- | --- | --- | --- | --- | --- |
| * **Do you take a blood thinning medication?** Common blood thinning medications are: Aspirin, Brilinta (Tricagrelor), Coumadin (Warfarin), Plavix, Pradaxa, Xarelto, Imbruvica (Ibrutinib) | | | 🞏 No | | 🞏 Yes | |
| * **Do you have an artificial heart valve?** | | | 🞏 No | | 🞏 Yes | |
| * **Do you require antibiotics prior to a surgical procedure?** | | | 🞏 No | | 🞏 Yes | |
| * **Do you have a defibrillator and/or pacemaker?** | | | 🞏 No | | 🞏 Yes | |
| * **Have you had an artificial joint replacement within the past two (2) years?** If yes, when and what body locations? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | 🞏 No | | 🞏 Yes | |
| * **Have you been diagnosed as having human immunodeficiency virus (HIV)?** | | | 🞏 No | | 🞏 Yes | |
| * **Have you been diagnosed as having Hepatitis B or C?** | | | 🞏 No | | 🞏 Yes | |
|  | | |  | |  | |
| **FEMALE PATIENTS PLEASE ANSWER THE FOLLOWING QUESTIONS:** | | | | | | |
| * Are you trying to become pregnant? | 🞏 N/A | 🞏 No | | 🞏 Yes | | 🞏 Maybe |
| * Are you currently pregnant? | 🞏 N/A | 🞏 No | | 🞏 Yes | | 🞏 Maybe |
| * Are you currently nursing? | 🞏 N/A | 🞏 No | | 🞏 Yes | |  |
| * If you are of child-bearing potential, are you using contraception? | 🞏 N/A | 🞏 No | | 🞏 Yes | |  |
| If yes, what contraception are you currently using? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

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| **PATIENT Signature (or Parent/Guardian or POA):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |