Richard Hope, M.D.
Justin Clark, M.D.
Chasidy Marquis, F.N.P.
Kristen Farquhar, P.A.
Jennifer Gamez, F.N.P.

LUBBOCK DERMATOLOGY
AND SKIN CANCER CENTER

North Location
3601 22nd Street
Lubbock, Texas 79410
Office (806) 796-7193
Fax (806) 796-0034

South Location
5103 98th Street, Ste. 200
Lubbock, Texas 79424
Office (806) 796-7193
Fax (806) 368-8193

PATIENT HISTORY FOR S-O-A-P MEDICAL RECORDS SYSTEM

Please note that all the information is strictly confidential and cannot be accessed by other computer systems.

Date_____

Last Name_____

First Name_____

Middle Name_____

Date of Birth_____Gender_____

Occupation_____

Lives with_____
(i.e., alone, wife, husband, son, parents, etc.)

Social Security Number_____

Street Address/P.O. Box_____

City_____State_____

Zip Code_____

Phone Numbers : Check Preferred #

❑ Cell ( )_____

❑ Home ( )_____

❑ Work ( )_____Place_____

Emergency ( )_____Contact_____

Primary Care Physician_____

Referred by Name_____
(❑ Physician ❑ Patient of Ours ❑ Other)

Preferred Pharmacy_____

List all medications that you are currently taking. Include all medications prescribed by other physicians, over the counter medications, birth control pills, vitamins, and pain medications including aspirin.

❑ **See attached list provided by patient**

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies to medications? ❑ Yes ❑ No
If yes, please list drug and reaction

_____

_____

_____

_____

_____

Do you...			**Daily Amount**
Smoke?	**❑ Yes**	**❑ No**	**How Much?**_____
Drink Coffee?	**❑ Yes**	**❑ No**	**How Much?**_____
Drink Alcohol?	**❑ Yes**	**❑ No**	**How Much?**_____
Take Supplements?	**❑ Yes**	**❑ No**	**How Much?**_____

COVID-19 Vaccine: Yes ___ No ___

(Please fill out the other side)

Reviewed ___

Please list all major medical problems. Also list skin problems for the past and present, including acne, psoriasis, skin cancer, etc.

Problem / Procedure	Date	Physician

Adult Immunizations **Date**

Shingrix _____

Influenza (flu) _____

Gardasil _____

Please list health problems within your family

Father_____

Mother_____

Brothers/Sisters_____

Children_____

Review of Symptoms
(check any symptoms you have and make comment)

General / Endocrine: ❑ weight change ❑ fever ❑ sweating

Neurological / Psychiatric: ❑ headache ❑ crawling ❑ sensation

Heart / Respiratory: ❑ swollen ankles ❑ wheezing

Gastrointestinal / Genitourinary: ❑ nausea ❑ warts ❑ blisters

Hematologic / Lymphatic: ❑ swollen nodes ❑ painful nodes
❑ red streaking ❑ bleeding ❑ bruising

Allergic / Immunologic: ❑ hay fever ❑ asthma ❑ eczema

Skin: ❑ itching ❑ infection ❑ acne ❑ new growth ❑ rash ❑ warts

Do you have?

Artificial heart valves ❑ Yes ❑ No

Artificial Joints ❑ Yes ❑ No

Defibrillator Device ❑ Yes ❑ No

Have you had?

Rheumatic Fever ❑ Yes ❑ No

Mitral Valve Prolapse ❑ Yes ❑ No

Pediatric Immunizations

Are these up-to-date? ❑ Yes ❑ No

If not, which are lacking?_____

Is there a family history of:

Skin Cancer ❑ Yes ❑ No Who?_____

Melanoma ❑ Yes ❑ No Who?_____Living?____

Atopic Disorders ❑ Yes ❑ No ❑ asthma ❑ hay fever ❑ eczema

Psoriasis ❑ Yes ❑ No Who?_____

Other Skin Disease ❑ Yes ❑ No

Who / What?_____

_____

_____

_____

_____

_____

_____

What is bothering you <u>most</u> about your skin today?

_____

_____

_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Release of Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

I authorize records released FROM OR TO:

Lubbock Dermatology and Skin Cancer Center

Richard Hope, M.D., Justin Clark, M.D., Chasidy Marquis, F.N.P., Kristen Farquhar, F.N.P., Jennifer Gamez, F.N.P.

North Clinic
3601 22nd Street Lubbock, TX 79410
(806) 796-7193 Phone (806) 796-0034 Fax

South Clinic
5103 98th Street, Ste. 200 Lubbock, TX 79424
(806) 796-7193 Phone (806) 368-8193 Fax

Released TO OR FROM:
Name/Clinic/Doctor: _____

Address: _____City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Type or extent of information to be released (check all applicable categories):

____ Medical history, examination reports ____ Lab reports ____ Operation reports ____ Prescriptions

____ Treatments or tests ____ Consultations ____ X-ray reports ____ Other (Specify)

Purpose or need for release (PLEASE BE SPECIFIC): _____

This authorization will remain in effect for ninety (90) days per Texas State Law. This authorization will be effective for medical records generate to the date of signature.
I understand I may revoke this authorization at any time by providing a written revocation.

Signature of Patient or Legal Representative: _____ Date: _____

Relationship to Patient: _____

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold LUBBOCK DERMATOLOGY liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative: _____ Date: _____

Relationship to Patient (If Legal Representative): _____

FOR OFFICE USE ONLY

Received: _____ Completed By: _____
Mailed: _____ Fee Paid: _____