

Anh V. Nguyen, Dermatologist  
Adam V. Nguyen, Dermatologist

ADVANCED DERM-PLASTIC, P.A.  
455 School Street #49  
Tomball, TX 77375  
281-351-9823

Anson V. Nguyen, Plastic Surgeon  
Info@advanceddermtx.com

Date: \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

GENDER: ☐ MALE ☐ FEMALE

SOCIAL SECURITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME: \_\_\_\_\_ CELL: \_\_\_\_\_ PREFERRED CONTACT: ☐ EMAIL ☐ CELL

EMAIL: \_\_\_\_\_

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER: \_\_\_\_\_

EMERGENCY CONTACT: FULL NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

**PREFERRED PHARMACY:** \_\_\_\_\_ **NUMBER:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**NAME OF PARENT OR RESPONSIBLE PERSON:** ☐ SAME AS PATIENT ☐ PARENT ☐ OTHER \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**POLICY HOLDER INFORMATION:** ☐ SAME AS PATIENT ☐ PARENT ☐ OTHER \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ RELATIONSHIP TO PATIENT: ☐ PARENT ☐ SPOUSE ☐ OTHER \_\_\_\_\_

**REFERRING PROVIDER (If you were referred):** \_\_\_\_\_

### RELEASE OF INFORMATION

I, \_\_\_\_\_, HEREBY AUTHORIZE THE OFFICE OF ADVANCED DERM-PLASTIC, P.A.  
**TO RELEASE ALL MEDICAL INFORMATION TO:**  
*PRINT NAME*

1. **NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

2. **NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

3. **NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **RELATIONSHIP:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

**Your main reason for today's visit:** \_\_\_\_\_

**CURRENT MEDICATIONS:** \_\_\_\_\_

**MEDICATION ALLERGIES:** \_\_\_\_\_

**Allergies to: Topical Antibiotics, Adhesives, Lidocaine, Epinephrine**

Do you: Smoke: YES/NO (if yes: packs/day: \_\_\_\_\_ x \_\_\_\_\_ years) # of Children \_\_\_\_\_  
Drink? YES/NO (if yes, \_\_\_ glass/day) **WOMEN – Are you pregnant YES/NO**

**PLEASE CIRCLE THE FOLLOWING SYMPTOMS THAT YOU MAY HAVE:**

*FEVER	CHILLS	NIGHT SWEATS	WEIGHT CHANGES
*BLURRY VISION	DOUBLE VISION	LIGHT SENSITIVITY	
*NOSE BLEEDS	HEARING LOSS	RINGING IN EARS	
*CHEST PAIN	MURMURS	PALPITATIONS	
*COUGH	SPUTUM	WHEEZING	SHORTNESS OF BREATH
*NAUSEA	VOMITING	ABDOMINAL PAIN	DIARRHEA
	BLOODY/BLACK STOOL	APPETITE CHANGES	
*PAINFUL URINATION	FREQUENT URINATION	BLOODY URINE	INCONTINENCE
*JOINT PAIN	MUSCLE PAIN	WEAKNESS	
*CHANGES IN MOLES	NEW MOLES	ITCHING	RASHES
*LOSS OF BALANCE	DIZZINESS	CONFUSION	HEADACHE
	NUMBNESS	SEIZURES	FAINTING
*ABNORMAL IDEATION	ANXIETY	DEPRESSION	
*ANEMIA	BLEEDING PROBLEMS	LYMPHEDEMA	

**YOUR CURRENT OR PAST MEDICAL CONDITIONS/SURGERIES (please give details):**

AIDS/HIV _____	HEAD/EYES/EARS/NOSE/THROAT/MOUTH _____
HEART (AS A VALVE REPLACEMENT) _____	NEUROLOGIC/PSYCHOLOGICAL DISORDERS _____
DIGESTIVE SYSTEM _____	URINARY SYSTEM _____
SKIN DISORDERS _____	REPRODUCTIVE SYSTEM _____
LUNGS _____	THYROID/DIABETES/HORMONAL PROBLEMS _____
RHEUMATOLOGY _____	DYSPLASTIC MOLES _____
CARDIOVASCULAR DISORDERS _____	
ORTHOPEDIC DISORDERS (SUCH AS KNEE/HIP REPLACEMENT) _____	
PROSTHESIS/IMPLANTS (PACEMAKER OR PACEMAKER/DEFIBRILLATOR) _____	
CANCERS (SUCH AS SKIN CANCER, OVARIAN, THYROID, LUNG) _____	
*OTHER: _____	

**FAMILY HISTORY**

	MOTHER	FATHER	SIBLINGS	CHILDREN
Asthma	_____	_____	_____	_____
Cancers	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Eczema	_____	_____	_____	_____
Hay Fever/Allergies	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
Inflammatory Bowel (CROHN'S DISEASE/ULCERATIVE COLITIS)	_____	_____	_____	_____
Lung Disease	_____	_____	_____	_____
Lupus	_____	_____	_____	_____
Malignant Melanoma	_____	_____	_____	_____
Psoriasis	_____	_____	_____	_____

Other: \_\_\_\_\_