

**MEDICAL HISTORY FORM**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Zip Code \_\_\_\_\_ DL # \_\_\_\_\_ Sex \_\_\_ M \_\_\_ F Age \_\_\_\_\_ SS # \_\_\_\_\_  
Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer's Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Any other family members who have been treated here? \_\_\_ Yes \_\_\_ No Name \_\_\_\_\_  
How did you find out about our practice? \_\_\_\_\_

**RESPONSIBLE PARTY**

Name of Responsible Party \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Relationship: Husband/Wife/Father/Mother/Son/Daughter \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**IN CASE OF EMERGENCY CONTACT**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**PRIMARY INSURANCE CARRIER**

Name of Primary Insurance Company \_\_\_\_\_  
Mailing Address for Insurance Claim \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Relationship to Policyholder \_\_\_\_\_  
Name of Employer Group Policy \_\_\_\_\_ Group No. \_\_\_\_\_  
Policy or ID No. \_\_\_\_\_ Effective Date of Policy \_\_\_\_\_  
Phone Number for Verification \_\_\_\_\_  
Phone Number for Precertification \_\_\_\_\_

**SECONDARY INSURANCE CARRIER**

Name of Secondary Insurance Company \_\_\_\_\_

Mailing Address for Insurance Claim \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Relationship to Policyholder \_\_\_\_\_

Name of Employer    Group Policy \_\_\_\_\_ Group No. \_\_\_\_\_

Policy or ID No. \_\_\_\_\_ Effective Date of Policy \_\_\_\_\_

Phone Number for Verification \_\_\_\_\_

Phone Number for Precertification \_\_\_\_\_

**PAYMENT POLICY**

Full payment is encouraged the day of service. We accept MasterCard, Visa, Discover, American Express, a personal check, debit card or cash. Because Cooper Clinic is preventive in nature, the costs of the procedure may not be covered by insurance or Medicare. The business office will provide you with the necessary information to file or we can file for you for any out-of-network benefits. Patients are responsible for all payments.

**CANCELLATION POLICY**

When you schedule an appointment with our office, we reserve that time specifically for you. We appreciate at least 24-hour cancellation notice. If we do not receive 24-hour cancellation notice, this will be considered a "No Show" appointment. You will be billed an office visit of \$75.00.

**AUTHORIZATION**

I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits to Rick K. Wilson MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this form will have the same validity as the original.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please complete the following questionnaire as this will help us properly address the issues important to your health:**

Please list the purpose of your visit: \_\_\_\_\_

Present Health Concerns: \_\_\_\_\_

**1. Medical History**

Are you presently receiving medical treatment for any condition(s)?  Yes  No

If yes please list condition(s)

Condition	How Long

**2. Medications**

Please list any medications you take regularly. Prescription, non-prescription, vitamins, home remedies, birth control pills and herbs:  None

Medication (Including strength)	How many times a day	How long taken

**3. Allergies**

Are you allergic to any medications? (If yes, please list below)  Yes  No

Allergic to: \_\_\_\_\_

**4. Family History**

Has any blood relative every had skin cancer -----  Yes  No

If you answered "Yes" to the above, please specify relationship and medical problem below:

Relation	Age	Medical Problems	If deceased, cause of death	Age at death
Father				
Mother				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Father's Father				
Father's Mother				
Mother's Father				
Mother;s Mother				

**5. System Review**

Please place an "X" in the appropriate box or fill in the requested information:

Do you have any of the following:	Yes	No	Women Only:	Yes	No
1. Change in skin character			1. Number of times pregnant		
2. Unusual growth on skin			2. Now Pregnant		
3. Change in color or size of any mole			3. Number of miscarriages or abortions		
			4. Are you actively trying to prevent pregnancy i.e. birth control pills, condoms, etc.		

**6. Smoking**

Have you ever smoked: -----  Yes  No

If "No", proceed to the next section

If "Yes", at what age did you start: -----

Do you smoke now? -----  Yes  No

If "No", at what age did you stop: -----

Fill in the appropriate columns if you ever smoked

Quantity	Present	When you stopped
Cigarettes (no./day)		
Cigars (no./day)		
Pipe (pipefuls/day)		

**Rick K. Wilson, M.D.**  
**Adean Kingston, M.D.**  
*Medical, Surgical, and Laser Treatment for the Skin*

12200 Preston Road • Dallas, Texas 75230  
Phone: 972-560-6360/972-367-6900 • Fax: 972-367-6901

## Cosmetic Interest Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

What are your areas of **CONCERN**?  
(Please check all that apply)

- Frown lines between brow \_\_\_\_\_
- Fine lines and wrinkles to: \_\_\_\_\_
- Significant lines around – nose, mouth, eyes \_\_\_\_\_
- Downward turned corners of mouth \_\_\_\_\_
- Thinning lips \_\_\_\_\_
- Sagging skin \_\_\_\_\_
- Hollowness to cheeks \_\_\_\_\_
- Aging hands \_\_\_\_\_
- Facial redness \_\_\_\_\_
- Uneven skin tone / Texture \_\_\_\_\_
- Freckling / Hyperpigmentation \_\_\_\_\_
- Brown spots / Age spots \_\_\_\_\_
- Dark circles under eyes \_\_\_\_\_
- Facial veins \_\_\_\_\_
- Chest veins \_\_\_\_\_
- Leg veins \_\_\_\_\_
- Excessive sweating \_\_\_\_\_
- Damaged ear lobes, secondary to piercing \_\_\_\_\_
- Dry skin \_\_\_\_\_
- Sun protection \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Cosmetic procedures may not be done at time of initial visit due to time restraints.

**Rick K. Wilson, M.D.**  
*Medical, Surgical, and Laser Treatment for the Skin*

12200 Preston Road • Dallas, Texas 75230  
Phone: 972-560-6360 • Fax: 972-367-6901

## Leg Vein History Sheet

Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

1. When did your veins first appear? \_\_\_\_\_  
Age: \_\_\_\_\_ Before pregnancy: \_\_\_\_\_ After pregnancy: \_\_\_\_\_  
Other: \_\_\_\_\_

2. Have you been previously treated for this problem? \_\_\_\_\_

3. Is one leg worse than the other? \_\_\_\_\_ Right Left Same

4. How do the veins bother you?  
Sharp pain Yes No Aches/discomfort Yes No  
Congestion/pressure Yes No Swelling Yes No  
Itching Yes No Other \_\_\_\_\_

5. Have you ever had any of these problems?  
Clots in legs (phlebitis) Yes No Deep vein thrombosis Yes No  
Clots in lungs (embolus) Yes No Leg/ankle veins Yes No  
Vein X-Rays (venogram) Yes No Taken blood thinners Yes No

6. Have you tried conservative management of your varicose veins?  
Walking? Yes No How long? \_\_\_\_\_  
Avoidance of prolonged standing Yes No How long? \_\_\_\_\_  
Frequent elevation of affected leg(s) Yes No How long? \_\_\_\_\_  
Consistent use of therapeutic class II-IV compression stockings? Yes No  
A. Class II - up to 30 mmHG How long? \_\_\_\_\_  
B. Class III - up to 30-40 mmHG How long? \_\_\_\_\_  
C. Class IV - 760 mmHG How long? \_\_\_\_\_

7. Do you have you ever had any of the following?  
Diabetes Yes No Thyroid disease Yes No  
High blood pressure Yes No Heart disease/attack Yes No  
Jaundice or Hepatitis Yes No Cancer Yes No  
Septicemia Yes No Lupus Yes No  
Migraine Headaches Yes No Asthma Yes No  
Swollen feet or ankles Yes No Easy bruising/free bleeding Yes No  
Leg pain caused by walking Yes No Major leg injury Yes No  
Weight change of 10 lbs. in last 6 months Yes No

8. Are you pregnant? Yes No Are you breast feeding? Yes No

9. List hormones you have taken and dates of usage: \_\_\_\_\_

10. List current medications you are taking: \_\_\_\_\_

11. List all allergies: \_\_\_\_\_

12. Have you ever smoked? Yes No Are you currently smoking? Yes No

13. Are you developing new veins? Yes No Are your present veins bigger? Yes No

14. After prolonged sitting or standing do your legs ache? Yes No

15. Do your legs or veins hurt before menses? Yes No

16. Does walking or exercise relieve or aggravate the pain? Relieve Aggravate

17. List the family members who have this problem: \_\_\_\_\_



## Authorization to Communicate Confidential Information to Specific Individuals

Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

1. I authorize the use or disclosure of my health information as described below.
2. I authorize **Cooper Clinic** to communicate my health information to the individuals listed below.
3. The type of information to be communicated: **Comprehensive Medical Exam Report (which may include laboratory studies, X-ray reports, MDCT reports, ECG and exercise test reports and other associated reports), follow-up appointments and testing, payment status, reminders, etc.**
4. In addition to myself, this type of information may be communicated by: faxing, mailing, telephone and email to the individuals listed below (**PLEASE PRINT**): (examples: secretaries, spouses, relatives, etc)

Individual's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Individual's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Individual's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Individual's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

For the purpose of: **Continuity of Medical Care**

5. I understand that this authorization may be revoked in writing at any time by contacting the Cooper Clinic director of medical compliance. I understand that any revocation will not apply to information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization will expire: INDEFINITELY: \_\_\_\_\_ (please mark) OTHER: \_\_\_\_\_** If I fail to check indefinitely or specify other, this authorization will expire in **six months (180 days)**.
6. I understand that authorizing the disclosure of this health information is voluntary. I understand that Cooper Clinic will not condition payment or treatment based upon this authorization for release of information. I understand that any disclosure of information has the potential for unauthorized re-disclosure, and that the disclosed information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative – Relationship to the Patient