Initial History and Physical Exam

Patient Name:_______________________________ Today's Date:_______________________________

Date of Birth:_______________________________ Male____ Female____

Fizpatrick: I II III IV V VI

HPI____
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Patient to Complete:

Medical Conditions/Family Medical History (P=Patient F=Family)

Condition	P/F	Condition	P/F	Condition	P/F
No Medical Conditions	P__F__	Fungal Infection	P__F__	PCOS	P__F__
Acid Reflux	P__F__	Hashimoto Thyroid Disease	P__F__	Precancerous Skin Lesions	P__F__
Acne	P__F__	Heart Arrhythmia	P__F__	Psoriasis	P__F__
Actinic Keratosis	P__F__	Herpes Simplex	P__F__	Raised Moles	P__F__
ADD/ADHD	P__F__	High Blood Pressure	P__F__	Rheumatoid Arthritis	P__F__
Alopecia	P__F__	High Cholesterol	P__F__	Rosacea	P__F__
ALS/Lou Gehrig's Disease	P__F__	HIV/AIDS	P__F__	Sarcoidosis	P__F__
Anxiety	P__F__	Hormone Imbalance	P__F__	Seasonal Allergies	P__F__
Asthma	P__F__	Hyperthyroidism	P__F__	Seizures	P__F__
Bell's Palsy	P__F__	Hypothyroidism	P__F__	Sexual Dysfunction	P__F__
Blood Clotting Disorder	P__F__	Impetigo	P__F__	Shingles	P__F__
Cancer	P__F__	Keloid Scarring	P__F__	Sjogren's Syndrome	P__F__
Celiac Disease	P__F__	Keratosis Pilaris	P__F__	Smoke	P__F__
Charcot Marie Tooth Dx	P__F__	Lambert-Eaton Syndrome	P__F__	Stroke	P__F__
Cold Sores/Fever Blisters	P__F__	Lupus/Scleroderma	P__F__	Urinary Incontinence	P__F__
Congestive Heart Failure	P__F__	Melanoma/Skin Cancer	P__F__	Varicose Veins	P__F__
COPD	P__F__	Melasma	P__F__	Vasculitis	P__F__
Depression	P__F__	Migraines	P__F__	Vitiligo	P__F__
Diabetes	P__F__	Multiple Sclerosis	P__F__	Warts	P__F__
Digestive Problems	P__F__	Muscle Weakness/Tremors	P__F__	Other:_______________	
Eczema	P__F__	Muscular Dystrophy	P__F__	_______________	
Erectile Dysfunction	P__F__	Myasthenia Gravis	P__F__	_______________	
Fatigue	P__F__	Parkinson's Disease	P__F__	_______________	
Fibromyalgia	P__F__	Peripheral Neuropathy	P__F__	_______________	

Allergies:____
____

Current Medications:
____
____
____
____

Surgeries:____
____

REVIEW OF SYSTEMS

General Well-Being:	N	Y
Activity Change	Y	Y
Appetite Change Chills	Y	Y
Excessive Sweating	Y	Y
Fatigue	Y	Y
Temperature of 100 degrees or greater	Y	Y
Weight Change	Y	Y
Head, Ears, Nose, Mouth, Throat:		
Headaches	Y	Y
Ear Discharge	Y	Y
Hearing Loss	Y	Y
Ear Pain	Y	Y
Ringing in Ears	Y	Y
Nosebleeds	Y	Y
Congestion/runny nose	Y	Y
Sneezing	Y	Y
Sore throat	Y	Y
Hoarse voice	Y	Y
Trouble swallowing	Y	Y
Eyes:		
Eye discharge	Y	Y
Itching Eyes	Y	Y
Eye pain	Y	Y
Eye redness	Y	Y
Light sensitivity	Y	Y
Visual disturbance	Y	Y
Respiratory		
Cough	Y	Y
Wheezing	Y	Y
Shortness of breath:	Y	Y
At Rest	Y	Y
With activity	Y	Y
Chest tightness	Y	Y
Snoring	Y	Y
Choking	Y	Y
Phlegm	Y	Y
Cardiovascular:		
Chest pain	Y	Y
Chest pain with activity	Y	Y
Rapid/irregular heartbeat	Y	Y
Shortness of breath while lying down	Y	Y
Leg cramping with walking	Y	Y
Leg swelling	Y	Y
Shortness of breath or coughing at night	Y	Y

Gastrointestinal:	N	Y
Heartburn	Y	Y
Nausea	Y	Y
Vomiting	Y	Y
Abdominal pain	Y	Y
Constipation	Y	Y
Diarrhea	Y	Y
Stool leakage	Y	Y
Rectal Bleeding	Y	Y
Blood in stool	Y	Y
Genitourinary:		
Difficulty urinating	Y	Y
Painful urination	Y	Y
Incontinence	Y	Y
Side pain	Y	Y
Frequent urination	Y	Y
Blood in urine	Y	Y
Urgency	Y	Y
Excessive urine amount	Y	Y
Musculoskeletal:		
Neck pain	Y	Y
Back pain	Y	Y
Joint pain	Y	Y
Joint swelling	Y	Y
Muscle pain	Y	Y
Walking problem	Y	Y
Falls	Y	Y
Neurological:		
Dizziness	Y	Y
Light-headedness	Y	Y
Speech difficulty	Y	Y
Loss of consciousness	Y	Y
Seizures	Y	Y
Numbness/tingling	Y	Y
Tremors	Y	Y
Weakness	Y	Y
Endocrine/Hematology/Allergy:		
Enlarged lymph nodes	Y	Y
Bleeding	Y	Y
Bruising	Y	Y
Environmental allergies	Y	Y
Excessive thirst	Y	Y
Psychiatric:		
Depression	Y	Y
Suicidal ideas	Y	Y
Anxiety	Y	Y
Hallucinations	Y	Y
Self-injury	Y	Y
Sleep problems	Y	Y
Hyperactive	Y	Y
Behavior problem	Y	Y
Decreased concentration	Y	Y

Skin:	N	Y
Itching	Y	Y
Color change	Y	Y
Pale	Y	Y
New spots	Y	Y
Change spots	Y	Y
Rash	Y	Y
Wounds	Y	Y
Nail changes	Y	Y
Hair changes	Y	Y
Breasts:		
Breast lump	Y	Y
Nipple discharge	Y	Y
OTHER____________________		
Males Only:		
Penile discharge	Y	Y
Testicular pain	Y	Y
Problems with sexual ability	Y	Y
Females Only:		
Abnormal pap smear	Y	Y
Bleeding between periods	Y	Y
Hot flashes	Y	Y
Vaginal discharge	Y	Y
LMP ____________________		
Last Pap Smear ____________________		
Last mammogram ____________________		
Pregnant	Y	Y

OTHER:

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Previous Treatments: Y____N____Explain (what/where/when/complications)

____

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____

Comments:____

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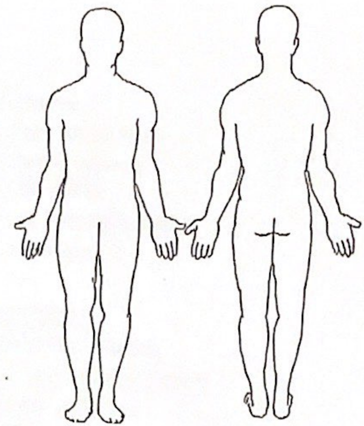
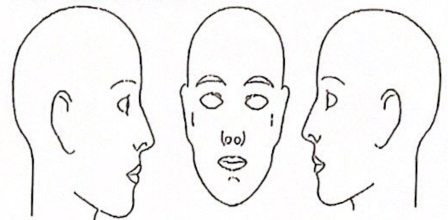
PHYSICAL REVIEW

GENERAL:	N	Y
Alert & Oriented	Y	Y
No acute distress	Y	Y
Well-developed	Y	Y
Appears stated age	Y	Y
SKIN:		
Warm, dry, and intact	Y	Y
Rashes or lesions	Y	Y
Appropriate color for ethnicity	Y	Y
HEAD:		
Normocephalic	Y	Y
Hair normal texture	Y	Y
Hair normal distribution	Y	Y

NECK:	N	Y
Supple w/o adenopathy	Y	Y
Trachea midline	Y	Y
Thyroid gland w/o mass	Y	Y
RESPIRATORY:		
No signs of resp distress	Y	Y
Respirations even, unlabored	Y	Y
NEUROLOGIC:		
Motor function grossly intact	Y	Y
Memory and thought process intact	Y	Y
PSYCHIATRIC:		
Appropriate mood and affect	Y	Y
Good judgement and insight	Y	Y





Comments:

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CLINICAL ASSESSMENT

- ☐Acne (facial)
- ☐Acne (non-facial)
- ☐Alopecia
- ☐Becker Nevus
- ☐Cafe-au-lait macules
- ☐Complexion-Dull
- ☐Desired Weight Loss
- ☐Dyschromia
- ☐Fatigue
- ☐Hemangioma
- ☐Hemosiderin
- ☐Hyperhidrosis
- ☐Hyperpigmentation
- ☐Hypopigmentation
- ☐Keratosis
- ☐Leg Veins
- ☐Lentigines
- ☐Lichen Sclerosus
- ☐Melasma
- ☐Pigmented Lesions
- ☐Poikiloderma
- ☐Port Wine Stain
- ☐Rhytids Static
- ☐Rhytids with Movement
- ☐Rosacea
- ☐Scarring/Keloid
- ☐Sexual Dysfunction
- ☐Skin Laxity
- ☐Skin Tags
- ☐Telangiectasia
- ☐Unwanted hair
- ☐Unwanted tattoo
- ☐Urinary incontinence
- ☐Volume loss

Other:

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___Accutane in last 6 months ___Photosensitivity ___Bacterial/fungal infection ___Scleroderma

___Hemorrhagic ___Sun/Tanning

Cancer:___Y___N Type:______________ Date:______________

Pregnant or B/F: Y___N___ LMP:__________ GYN:______________

T... esthetician will fill out. AP

DIAGNOSIS & TREATMENT PLAN FOR AESTHETIC PROCEDURES:

[___]SCITON BBL PER PROTOCOL

____Pigmented Lesions
- ____Lentigines
- ____Becker Nervus
- ____Keratosis
- ____Cafe-au-lait macules
- ____Hyperpigmentation

____Skin Treatments
- ____Rosacea/Telangiectasia
- ____Age Spots/Telangiectasia
- ____Erythema of Rosacea
- ____Melasma
- ____Polikoderma
- ____Acne

____Vascular Lesions
- ____Port Wine Stain
- ____Hemangioma
- ____Leg Veins
- ____Leg Telangiectasias
- ____Angiomas

[___]DIVA per protocol
- ____Skin Resurfacing
- ____Urinary Incontinence

[___]HALO BBL per protocol
- ____Rhytids
- ____Dyschromia
- ____Pigmented Lesion

[___]BOTOX COSMETIC UP TO 400 UNITS PER YEAR at 3 MONTH INTERVALS
- ____Glabellar Lines
- ____Lateral Canthal Lines
- ____Forehead Lines
- ____Rhytids

[___]JUVEDERM FAMILY OF FILLERS UP TO 20 ML/YEAR

[___]JUVEDERM ULTRA PLUS XC PER PROTOCOL
- ____Rhytids
- ____Perioral Rhytids
- ____Volume Deficit

[___]JUVEDERM VOLLURE PER PROTOCOL
- ____Rhytids
- ____Perioral Rhytids
- ____Volume Deficit

[___]JUVEDERM ULTRA PLUS XC PER PROTOCOL
- ____Rhytids
- ____Perioral Rhytids
- ____Volume Deficit

[___]JUVEDERM VOLUMA PER PROTOCOL
- ____Rhytids
- ____Perioral Rhytids
- ____Volume Deficit

[___]PLATELET RICH PLASMA W/SKINPEN PER PROTOCOL
- ____Rhytids Static
- ____Rhytids w/ movement
- ____Skin Rejuvenation
- ____Acne Scarring

[___]FRACTIONAL RF MICRONEEDLING PER PROTOCOL
- ____Skin Laxity
- ____Scarring
- ____Rhytids Static
- ____Rhytids w/ movement

[___]CRYOCLEAR PER PROTOCOL
- ____Skin Tags
- ____Sun Spots
- ____Age Spots/Telangiectasia

[___]SKINPEN MICRONEEDLING PER PROTOCOL
- ____Acne Scarring

[___]VI PEEL PER PROTOCOL
- ____Rhytids Static
- ____Rosacea
- ____Skin Rejuvenation

[___]VI PEEL PRECISION PLUS PER PROTOCOL
- ____Rhytids Static
- ____Rosacea
- ____Skin Rejuvenation
- ____Hyperpigmentation
- ____Melasma

[___]DERMAPLANING PER PROTOCOL
- ____Complexion – Dull
- ____Rhytids Static

The aesthetician will fill out. AP

TREATMENT NOTES:

____

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____

____

___Items listed in subparagraphs (A) – (J) of paragraph 2 of Texas Medical Board rule 193.17 completed

___Patient history and physical exam completed via telemedicine

Technician Signature:______________________________________ Date:______________

Nurse Practitioner Signature:__________________________ ________ Date:______________

Medical Director Signature:_____________________________________ Date:______________
MD, FACS

The aesthetician will fill out + Dr. will sign off. A.P.

Notes, progress notes, H+P notes from Dictation in EHR:

TEXAS HEALTH CARE, P.L.L.C.

923 PENNSYLVANIA AVE.
FORT WORTH, TEXAS 76104

MEDICATION/HERB LIST

DRUG ALLERGIES:

PHARMACY:

FOOD ALLERGIES:

PHARMACY PHONE NUMBER:

Medication/Herb	Dosage	Frequency

Texas Health Care, P.L.L.C.

HIPAA Authorization for Release of Patient Health Information

In general, HIPAA (Health Insurance Portability & Accountability Act) gives patients the right to request the uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications, or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home. This information will remain in effect until revoked in writing, except to the extent that action has already been taken.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home or Cell Phone: ______________________
  - ○ OK to leave a message with detailed information
  - ○ Leave name and doctor with call back number only
- ☐ Work Telephone: ______________________
  - ○ OK to leave message with detailed information
  - ○ Leave name & doctor with call back number only
- ☐ When unable to contact me by phone, a written communication may be sent to my home address.
- ☐ Other: ______________________

I consent and authorize the release of **NORMAL** test results to the following:

- ☐ Only Myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: ______________________
- ☐ My children: ______________________
- ☐ My parents: ______________________
- ☐ Other: ______________________

I consent and authorize the release of **ABNORMAL** test results to the following:

- ☐ Only myself
- ☐ Telephone Answering Machine/Voice Mail
- ☐ My spouse: ______________________
- ☐ My children: ______________________
- ☐ My parents: ______________________
- ☐ Other: ______________________

I consent and authorize your office or a facility on my behalf, to conduct benefit verification services.

- ☐ Yes
- ☐ No

I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- ☐ Yes
- ☐ No

ADVANCED DIRECTIVE

Do you have an advanced directive (Living Will)?

- ☐ Yes
- ☐ No

____

Patient Signature (Must be an adult 18yrs or older) Date

____

Print Name Birthdate

Texas Health Care, P.L.L.C.

923 PENNSYLVANIA AVE.
FORT WORTH, TEXAS 76104

PAYMENT POLICY

Thank you for choosing Texas Health Care, the office of Dr. Yadro Ducic, Dr. Jesse Smith, Dr. Andrew Vories, Dr. Ricardo Cristobal, Amanda Hudson, RN, MSN, FNP, Lauren LeBlanc, RN, ACNP, Amy Williamson, RN, ACNP, Dr. Lindi Berry, Dr. Amy Zahn, Dr. Stevie Daniel and Katrina Jensen, M.A., CCC-SLP. We are committed to providing you with quality and affordable health care. Some of our patients have had questions regarding patient and insurance responsibility for services rendered; due to this we have developed this payment policy. Please read it, ask us any questions you may have and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan that we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Medicare beneficiaries are required to notify our office if enrolled in home health care or a skilled nursing unit. If our office is not notified, you may be liable for services rendered.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account balance is past due, you will receive a letter requesting that you pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your scheduled appointment, please give a 24-hour notice to avoid being charged. We reserve the right to charge for missed or untimely canceled appointments. Excessive abuse of scheduled appointments may result in discharge from practice.

I have read and understand the payment policy and agree to abide by it's guidelines:

____

Signature of Patient or Responsible Party

____

Date

THC82P80