|  |  |
| --- | --- |
|  | **DR. DAVID W. JUDY**  **TJ DOUGLAS, PA-C, KATIE CARPENTER, PA-C**  **LAUREN SHAFFER, PA-C**  **4202 MCCORKLE AVE. SW, SOUTH CHARLESTON, WV, 25309**  **PHONE: 304-925-SKIN(7546) – FAX: 681-205-8369** |

**PATIENT INFORMATION DATE:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Main Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home / Cell / Work Secondary #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home / Cell / Work

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Where may we leave **appointment reminders?** (Circle): Main phone (text), Secondary phone (text), Email, None
* Where may we leave **medical information?** (Circle): Main phone (Vmail), Secondary phone (Vmail), Email, None

Present/Former Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact(s):**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE**

**Primary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Secondary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group: \_\_\_\_\_\_\_\_\_\_\_ Card ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group: \_\_\_\_\_\_\_\_\_\_\_

Name on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name on card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL RECORDS RELEASE**

**In the list below, include anybody (family members, physicians, etc.) you would like to have access to your medical information and history.** By signing below, you authorize West Virginia Dermatology & Skin Surgery Center to disclose and/or release your medical information (pertaining to your diagnosis, treatment, laboratory results, medical history, etc.) to the individuals listed below. You authorize a copy of this signed document to be used in place of the original.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ I would rather not add anybody**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**POLICIES AND STATEMENTS**

**Please read the following statements carefully and sign below. If you have questions regarding any of these, please discuss them with our office manager at 304-925-SKIN (7546). Thank you for choosing our office for your care!**

All of the information I have provided in these forms is current, complete, and accurate. It is my responsibility to update information on file if it changes. My signature below will be used as my “signature on file” for comparing to other signatures where necessary. I permit a copy of this authorization form to be used in place of the original.

**Treatment and Release of Medical Information**

* I authorize my medical information to be released to West Virginia Dermatology, to my primary care physician’s office, to my referring physician’s office, and to insurance companies and their agencies (including Medicare) as needed for my treatment, or to process and file my medical claims.
* I authorize my treatments, anesthetics, and procedures to be administered by any of the physicians and staff of West Virginia Dermatology.

**Late and No-Show Policy**

West Virginia Dermatology is allowed to reschedule me if I am late. If I do not show up to an appointment, or if I cancel within 24 hours, I will be issued a no-show fee ($25 for a regular visit, or $150 if it was for a procedure or surgery) which my insurance will not cover. If I have two no-show appointments, West Virginia Dermatology will no longer see me as a patient. I may submit a written request for my medical records to be sent to another physician.

**Insurance**

* I am aware that my insurance policy is a contract between my insurance company and I only. It is therefore my responsibility to understand my outline, including my copayments, co-insurance, and any deductibles I may have.

I am (or my accompanying party is) responsible for payments due at the time of service, and I am (or my responsible party is) ultimately responsible for everything my insurance will not pay. This includes anything my insurance declares “not medically necessary,” “cosmetic,” or “not covered,” and payments they refuse to pay if I fail to notify West Virginia Dermatology of insurance changes before my appointment. I am aware that although my insurance benefits may be verified at the time of service, this does not mean that they will pay for the expenses.

* If my insurance is not in network with West Virginia Dermatology, or if I do not have insurance, I am responsible for my treatment and visit expenses at the time of service. West Virginia Dermatology would be happy to help me file a claim with my insurance company.
* I authorize my insurance payment benefits to be paid directly to West Virginia Dermatology.

**Balances and External Charges**

* Balances are due within 30 days of the date shown on the statement. West Virginia Dermatology will work with me on a payment plan if needed, but if these efforts do not resolve the balance, my account may be sent to a collection agency, in which case all fees charged by the collection agency would become my responsibility as well.
* If I need laboratory services (such as pathology or wound culture), the laboratory will give me a separate bill.

**Dependents**

* **Minors** must be accompanied by their legal parent/guardian, or have written permission from their legal parent/guardian to be brought to appointments by somebody else or be seen without an adult (if they are age 16 or older). Payments due at the time of service must still be paid by the accompanying party or by the patient.
* **Patients who have a Medical Power of Attorney (MPOA) and cannot make decisions or sign consent** must have their MPOA present and their MPOA papers scanned into their file before being seen.

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**My signature shows that I have read, understand, and agree to all the statements and policies above.**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL CARE INFORMATION**

Primary care physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Was a medical referral sent to us? Yes / No

**Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Has someone been designated as the patient’s **Medical Power of Attorney** (MPOA)? Yes / No  MPOA’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MPOA’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_  **Please provide a copy of MPOA papers.** If patient cannot make decisions or sign consent, MPOA must be present. |

**Most recent… Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_, Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_, Blood Pressure: \_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_**

**PERSONAL MEDICAL HISTORY: Circle all that apply, or circle NONE. For items marked \*\*, please describe below.**

|  |  |  |
| --- | --- | --- |
| Alzheimer’s  Anxiety  Arthritis  Asthma  Autoimmune Disorder  Atrial Fibrillation  Bleeding Disorder\*\*  Bone Marrow Transplantation  Breast Cancer\*\*  Clotting Disorder  Colon Cancer  COPD  Coronary Artery Disease | Depression  Dementia  Diabetes  End Stage Renal Disease (Kidney Failure)  Enlarged Prostate  GERD  Hearing Loss  Hepatitis, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  High Blood Pressure  HIV /AIDS  High Cholesterol  Hyperthyroidism  Hypothyroidism | Immunocompromised\*\*  Leukemia  Lung Cancer  Lymphoma  Pacemaker  Prostate Cancer  Radiation Treatment  Seizures  Stroke  Thrombocytopenia  Valve Replacement:  (Mechanical or Biological?)  **NONE** |

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

Please describe items marked with \*\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY: Please circle all that apply, or circle NONE**

|  |  |  |
| --- | --- | --- |
| Appendix removed  Bladder removed  Mastectomy (right, left, bilateral)  Lumpectomy (right, left, bilateral)  Breast biopsy (right, left, bilateral)  Breast reduction  Breast implants  Colectomy: Colon cancer resection  Colectomy: Diverticulitis  Colectomy: IBD  Gallbladder removed  Knee replacement (right, left, bilateral)  Hip replacement (right, left, bilateral) | Kidney biopsy  Kidney removed (right, left)  Kidney stone removal  Kidney transplant  Ovaries removed: Endometriosis  Ovaries removed: Cyst  Ovaries removed: Ovarian cancer  Prostate biopsy  Prostate removed: Prostate cancer  TURP  Testicles removed (right, left, bilateral)  Hysterectomy: Fibroids  Hysterectomy: Uterine cancer | Spleen removed  Coronary artery bypass  Stents  Mechanical valve replacement  Biological valve replacement  Heart transplant  Skin biopsy  Basal cell cancer surgery  Squamous cell carcinoma surgery  Melanoma surgery  **NONE** |

Other joint replacement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Surgery Complications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SKIN DISEASE HISTORY: Please circle all that apply, or circle NONE**

|  |  |  |  |
| --- | --- | --- | --- |
| Acne  Actinic keratoses  Asthma  Basal cell skin cancer | Blistering sunburns  Dry skin  Eczema  Flaking or itchy scalp | Hay fever / allergies  Melanoma  Poison ivy  Precancerous moles | Psoriasis  Squamous cell skin cancer  **NONE** |

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

Do you wear sunscreen daily? Yes / No -If yes, what SPF? \_\_\_\_\_\_\_\_\_\_

Do you use a tanning bed? Yes / No

**MEDICATIONS: List, or attach a list, showing all current medications including Dosage and Frequency.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DRUG ALLERGIES: List, or attach a list, showing all allergies to medications.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SOCIAL HISTORY: Please circle or checkmark all that apply.**

|  |  |  |
| --- | --- | --- |
| Alcohol use:  None  Less than 1 drink a day  1-2 drinks a day  3 or more drinks a day | Cigarette / Cigar smoking:  Never smoked  Former smoker  Smoke less than daily  Smoke daily | Do you use I.V. Drugs?  Yes / No  If yes, what do you use?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FAMILY MEDICAL HISTORY: Please circle all that apply to your mother, father, brothers/sisters, daughters/sons.**

|  |  |  |
| --- | --- | --- |
| Diabetes  Heart disease  Kidney disease  High cholesterol  Hypertension | Hyperthyroidism  Hypothyroidism  Bleeding disorders  Stroke  Autoimmune disorders | Melanoma  Psoriasis  Atopic dermatitis  Hay fever / allergies  Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

**REVIEW OF SYSTEMS: Please circle all that you are currently experiencing, or circle NONE**

|  |  |  |  |
| --- | --- | --- | --- |
| Problems with bleeding  Problems with healing  Problems with scarring  Rash  Hay fever  Chest pain | Fever or chills  Night sweats  Unintentional weight loss  Thyroid problems  Sore throat  Blurry vision | Abdominal pain  Bloody stool  Bloody urine  Joint aches  Muscle weakness  Neck stiffness | Headaches  Seizures  Cough  Shortness of breath / Wheezing  Anxiety / Depression  **NONE** |

**ALERTS: Please circle all that you are currently experiencing, or circle NONE**

|  |  |
| --- | --- |
| Allergic to adhesive  Allergic to lidocaine  Allergic to topical antibiotic ointments  Artificial heart valve  Artificial joints within the past 2 years  Blood thinners  Defibrillator  MRSA  Pacemaker  Premedication prior to procedure  Rapid heartbeat with epinephrine  Personal history of melanoma | Pregnant or planning to be pregnant  Perforated ear drum  Bleeding disorder  Myasthenia gravis  Organ transplant  Surgical scrub allergy  Latex allergy  Immunosuppression  Implantable device (pain pump, stimulator, etc)  Congenital heart disease  Thrombocytopenia or clotting disorder  **NONE** |

**Is the patient able to sign consent for surgeries / procedures?** (Circle): Yes / No

Thank you!