|  |  |
| --- | --- |
|  |  **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 / NoMPOA’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’sAnxietyArthritisAsthmaAutoimmune DisorderAtrial FibrillationBleeding Disorder\*\*Bone Marrow TransplantationBreast Cancer\*\*Clotting DisorderColon CancerCOPDCoronary Artery Disease | DepressionDementiaDiabetesEnd Stage Renal Disease (Kidney Failure)Enlarged ProstateGERDHearing LossHepatitis, Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_High Blood PressureHIV /AIDSHigh CholesterolHyperthyroidismHypothyroidism | Immunocompromised\*\*LeukemiaLung CancerLymphomaPacemakerProstate CancerRadiation TreatmentSeizuresStrokeThrombocytopeniaValve Replacement:(Mechanical or Biological?)**NONE** |

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

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

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

|  |  |  |
| --- | --- | --- |
| Appendix removedBladder removedMastectomy (right, left, bilateral)Lumpectomy (right, left, bilateral)Breast biopsy (right, left, bilateral)Breast reductionBreast implantsColectomy: Colon cancer resectionColectomy: DiverticulitisColectomy: IBDGallbladder removedKnee replacement (right, left, bilateral)Hip replacement (right, left, bilateral) | Kidney biopsyKidney removed (right, left)Kidney stone removalKidney transplantOvaries removed: EndometriosisOvaries removed: CystOvaries removed: Ovarian cancerProstate biopsyProstate removed: Prostate cancerTURPTesticles removed (right, left, bilateral)Hysterectomy: FibroidsHysterectomy: Uterine cancer | Spleen removedCoronary artery bypassStentsMechanical valve replacementBiological valve replacementHeart transplantSkin biopsyBasal cell cancer surgerySquamous cell carcinoma surgeryMelanoma surgery**NONE** |

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

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| AcneActinic keratosesAsthmaBasal cell skin cancer | Blistering sunburnsDry skinEczemaFlaking or itchy scalp | Hay fever / allergiesMelanomaPoison ivyPrecancerous moles | PsoriasisSquamous 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 / NoIf yes, what do you use?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

|  |  |  |
| --- | --- | --- |
| DiabetesHeart diseaseKidney diseaseHigh cholesterolHypertension | HyperthyroidismHypothyroidismBleeding disordersStrokeAutoimmune disorders | MelanomaPsoriasisAtopic dermatitisHay fever / allergiesCancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| Problems with bleedingProblems with healingProblems with scarringRashHay feverChest pain | Fever or chillsNight sweatsUnintentional weight lossThyroid problemsSore throatBlurry vision | Abdominal painBloody stoolBloody urineJoint achesMuscle weaknessNeck stiffness | HeadachesSeizuresCoughShortness of breath / WheezingAnxiety / Depression**NONE** |

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

|  |  |
| --- | --- |
| Allergic to adhesiveAllergic to lidocaineAllergic to topical antibiotic ointmentsArtificial heart valveArtificial joints within the past 2 yearsBlood thinnersDefibrillatorMRSAPacemakerPremedication prior to procedureRapid heartbeat with epinephrinePersonal history of melanoma | Pregnant or planning to be pregnantPerforated ear drumBleeding disorderMyasthenia gravisOrgan transplantSurgical scrub allergyLatex allergyImmunosuppressionImplantable device (pain pump, stimulator, etc)Congenital heart diseaseThrombocytopenia or clotting disorder**NONE** |

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

Thank you!