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**Diplomats of the American Board of Dermatology**

**General, Surgical and Cosmetic Dermatology**

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**Medical History**

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

Referring MD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Health Care Proxy, or would you like to name a surrogate decision maker? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Yes/No/Decline)

If Yes, please provide details below:

|  |  |
| --- | --- |
| Name: |  |
| Relationship: |  |
| Phone Number: |  |

Do you have an Advanced Care Directive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Yes/No/Decline)

If Yes, please provide details below:

|  |  |
| --- | --- |
| DNR: Do not Resuscitate |  |
| Full Cardiopulmonary Resuscitation |  |
| Other: |  |

Current Medications & Supplements

(If none, please print none)

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Dosage | Medication Name | Dosage |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Allergies

(If none, please print none)

|  |  |  |  |
| --- | --- | --- | --- |
| Allergy | Reaction | Allergy | Reaction |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Patient Past Medical History

(Please check appropriate boxes)

|  |  |  |  |
| --- | --- | --- | --- |
| No Pertinent Past Medical History |  | Hepatitis/HIV/Tuberculosis (TB) |  |
| Antibiotics prior to routine dental procedures |  | High blood Pressure |  |
| Asthma/COPD |  | Kidney Disorder |  |
| Autoimmune Disorder/Lupus |  | Liver Disorder |  |
| Bleeding Disorder |  | Neurologic disorder/MS/Dementia |  |
| Blood Clot/DVT/Thrombophlebitis |  | Pacemaker/Defibrillator |  |
| Cancer (other than skin cancer) |  | Radiation Therapy |  |
| Depression/Psychiatric Disorder |  | Reflux/Peptic Ulcers/Crohn’s/ Ulcerative Colitis |  |
| Diabetes |  | Thyroid Disorder |  |
| Heart Disease Murmur |  | Other History |  |

Skin History

(Please check appropriate Boxes)

|  |  |  |  |
| --- | --- | --- | --- |
| No Significant Skin History |  | Other Suspicious Lesion(s) |  |
| Actinic Keratosis |  | Eczema |  |
| Basal Cell Carcinoma |  | Seasonal/Food Allergies |  |
| Squamous Cell Carcinoma |  | Urticaria/Hives |  |
| Malignant Melanoma |  | Autoimmune Disorder/Lupus |  |
| Skin Cancer (Basal Cell/Squamous Cell Carcinoma |  | Keloids |  |
| Asthma |  | Abnormal Clotting/DVT |  |
| Seasonal Food Allergies |  | Other Family History, please list:  |  |

Past Surgical History

|  |
| --- |
| Name of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Social History

(Please check appropriate boxes)

|  |
| --- |
| Alcohol Consumption: None Socially Daily[ ] UV Exposure [ ]  Current Tanning bed use [ ]  Past tanning bed use [ ]  >5 Blistering sunburns  [ ] Use SunscreenSmoking Status: [ ] Current Smoker [ ]  Former Smoker [ ]  Never Smoked |

|  |
| --- |
| If child: is growth and development appropriate: [ ]  Yes [ ]  No Vaccinations up to date: [ ] Yes [ ] No |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Patient or Legal Guardian)