Carolina Dermatology
& SKIN CANCER SURGERY, P.A.

PATIENT INFORMATION

Name: _____ DOB: _____

Gender: _____ Race/Ethnicity: _____

Home Address: _____ City:_____ ZIP: _____

Phone (check preferred): ☐ Mobile: _____ ☐ Home: _____

Email: _____ Employer/Occupation: _____

Emergency Contact (name and number): _____

Insurance Policy Holder's Name (if not you)_____and DOB:_____

Preferred Pharmacy: _____ Location:_____

Allergies: _____

Hobbies: _____

Past Medical History: *check all that apply*

- ☐ None
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrilation
- ☐ Stroke
- ☐ Chronic obstructive lung disease
- ☐ Heart disease
- ☐ Depression
- ☐ Diabetes
- ☐ End-stage kidney disease
- ☐ Hypertension
- ☐ HIV
- ☐ High cholesterol
- ☐ Hepatitis
- ☐ Cancer: type _____
- ☐ Bone marrow transplant
- ☐ Other _____

Past Surgeries: *check all that apply*

- ☐ None
- ☐ Coronary artery bypass graft
- ☐ Kidney transplant
- ☐ Excision of Basal Cell Carcinoma
- ☐ Excision of Melanoma
- ☐ Excision of Squamous Cell Carcinoma
- ☐ Heart valve replacement
- ☐ Heart transplant
- ☐ Liver transplant
- ☐ Other _____

Skin Conditions: *check all that apply*

- ☐ None
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma
- ☐ Atypical Moles
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever
- ☐ Malignant Melanoma
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Other:_____

Do you wear sunscreen ☐ yes or ☐ no If yes, what SPF _____ Do you use a tanning bed? ☐ yes or ☐ no
Do you have a ***family history*** of melanoma ? ☐ yes or ☐ no If yes, who? _____

Do you smoke? ☐ yes ☐ no If yes, _____ pks/day Do you drink? ☐ yes ☐ no If yes, _____ drinks/ day

If over 65, do you have pneumonia vaccination? ☐ yes ☐ no
Do you have a legal healthcare proxy? ☐ yes ☐ no Do you have a living will? ☐ yes ☐ no