VISION
DERMATOLOGY
3200 BLUE RIDGE RD, STE 118,
RALEIGH, NC 27612
919-319-1901 PH
919-319-1906 F

Patient Information:

Patient Name: _____ Date of Birth: _____

Gender: _____ Height: _____ Weight: _____

Race: _____ Ethnicity: _____

Preferred Language: _____

Preferred Phone Number: _____ *Home / Mobile (please circle)*

Email Address: _____

Home Address: _____

City: _____ State:_____ Zip: _____

Primary Care Physician: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

Preferred Pharmacy:

Pharmacy Name: _____ City or Zip Code: _____

Phone Number: _____

Medical History:

Do you now have, or have you ever been diagnosed with the following conditions? (Check if Yes):

☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Cancer (Type:_____)
☐ Cold Sores or Fever Blisters
☐ COPD
☐ Depression
☐ Defibrillator
☐ Diabetes (Type: _____)
If yes, what is your most recent A1c?: _____

☐ End-Stage Renal Disease
☐ Epilepsy
☐ GERD/Acid Reflux
☐ Hearing Loss
☐ Heart Attack
☐ Heart Disease
☐ Hepatitis (Type: _____)
☐ High Blood Pressure
☐ High Cholesterol

☐ HIV/AIDS
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Irregular Heart Rhythm
☐ MRSA
☐ Pacemaker
☐ Radiation treatment
☐ Seizures
☐ Stroke

Have you been advised to take antibiotics prior to dental or surgical procedures?: ☐ Yes ☐ No

Do you get a rapid heartbeat with epinephrine?: ☐ Yes ☐ No

Do you have problems with healing?: ☐ Yes ☐ No or excessive scarring (keloid)?: ☐ Yes ☐ No

Current Medications:

(Please list all supplements and prescribed medications, including dosage)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

_____

_____

Are you allergic to Lidocaine or local anesthesia?:

☐ Yes ☐ No

Are you allergic to any adhesives?

☐ Yes ☐ No

Are you allergic to topical antibiotic ointments?:

☐ Yes ☐ No

Past Surgical History (Check if Yes):

☐ Breast Augmentation
☐ Breast Reduction
☐ Colectomy
☐ Coronary Artery Bypass
☐ Heart Valve Replacement
☐ Hip Replacement (Left, Right, Bilateral)
☐ Knee Replacement (Left, Right, Bilateral)
☐ Lumpectomy (Right, Left, Bilateral)
☐ Mastectomy (Right, Left, Bilateral)

☐ Organ Removal (If yes, please specify which): _____

☐ Organ Transplant (If yes, please specify which): _____

Other medical problems and/or major surgeries not listed above: _____

_____

_____

Skin Disease History (Check if Yes):

☐ Acne
☐ Actinic Keratosis/Precancerous Moles
☐ Basal Cell Carcinoma
☐ Blistering Sunburns
☐ Eczema
☐ Malignant Melanoma
☐ Psoriasis
☐ Rosacea
☐ Squamous Cell Carcinoma

Other: _____

Do you wear sunscreen? ☐ Yes ☐ No
If yes, what SPF?: _____

Do you have a family history of Melanoma? ☐ Yes ☐ No
If so, which relative?: _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Social History:

Tobacco Use (including e-cigarettes):

☐ Never smoker

☐ Current every day smoker

☐ Current some day smoker

☐ Former smoker

If you checked former smoker (please approximate):

What date did you start smoking? ____ / ____ / _____

What date did you stop smoking? ____ / ____ / _____

Number of packs smoked a day: _____

Total years smoking: _____

Alcohol Use:

☐ None

☐ Less than 1 drink per day

☐ 1-2 drinks per day

☐ 3 or more drinks per day

How many times in the past year have you had 5 or more drinks in one day?: _____

Do you use any recreational drugs?: ☐ Yes ☐ No

Advanced Care Planning (for patients 65 and older):

Have you received a pneumonia vaccine on or after your 60th birthday? ☐ Yes ☐ No

Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No

If Yes, please indicate: Designee's Name: _____

Designee's Phone Number: _____

Do you have a living will? ☐ Yes ☐ No

Which statement best reflects your wishes on advanced care recommendations?

☐ **Do Not Intubate:** I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ **Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.

☐ **Full Cardiopulmonary Resuscitation**: I want full cardiopulmonary resuscitation efforts to be made.

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

_____ _____

Patient Signature **Date**