CHARLESTON
DERMATOLOGY

Patient History

Name:_____ Date of birth:_____

Who is your primary care provider?

_____

What brings you in today? (please check one of the boxes below):

□ rash
□ mole, growth or other lesion of concern.
□ other (please explain):

_____

Where is it located? (please select all that apply)

□ scalp □ face □ chest □ back □ abdomen □ buttocks/groin
□ right arm □ left arm □ right leg □ left leg

How long has the above been present?

_____ days _____ weeks _____ months _____ years

Do any of these symptoms or descriptions apply ?

□ itching □ burning □ bleeding □ darkening □ enlarging □ not healing
□ flaking □ blistering □ other (please explain): _____

Have you tried any prescription or over-the-counter medications to treat this problem?

□ none
□ topical medicine (please specify) _____
□ oral antibiotic (please specify) _____
□ oral prednisone (please specify the dose and duration) _____
□ other (please specify the dose and duration) _____

Females only

Are you pregnant or planning a pregnancy?	□ yes	□ no
Are you a nursing mother?	□ yes	□ no

Skin Disease History: (please check all that apply):

□ None
□ Acne
□ Asthma
□ Blistering sunburns
□ Tanning salon use
□ Other:

□ Eczema
□ Hay fever/Allergies
□ Precancerous moles
□ Psoriasis

_____

Do you have a history of fever blisters? ☐ yes ☐ no

Have you ever had a skin biopsy? ☐ yes ☐ no

Have you ever had a skin cancer or "pre-cancer" (please check all that apply)?

- ☐ None
- ☐ Pre-cancers/Actinic Keratosis
- ☐ Basal cell carcinoma
- ☐ Squamous cell carcinoma
- ☐ Melanoma skin cancer

Do you have a family history of melanoma skin cancer?

☐ No ☐ Yes Which relative?

_____

Medical History

Please check all that apply:

- ☐ None
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Autoimmune disease: _____
- ☐ Bone Marrow Transplantation
- ☐ BPH (enlarged prostate)
- ☐ Breast cancer history
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Coronary Artery Disease
- ☐ Pacemaker or defibrillator
- ☐ Depression
- ☐ Diabetes
- ☐ Kidney disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High blood pressure (hypertension)
- ☐ HIV/AIDs
- ☐ High cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Prostate cancer
- ☐ Radiation treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other:_____

Past Surgical History:

Please check all that apply:

- ☐ None
- ☐ Appendix
- ☐ Breast _____
- ☐ Colon _____
- ☐ Gallbladder
- ☐ Heart: stent placement
- ☐ Heart: coronary artery bypass surgery
- ☐ Heart: biological valve replacement
- ☐ Heart: mechanical valve replacement
- ☐ Heart: heart transplant
- ☐ Joint replacement: left hip
- ☐ Joint replacement: right hip
- ☐ Joint replacement: left knee
- ☐ Joint replacement: right knee
- ☐ Kidney transplant
- ☐ Liver transplant
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Other:_____

Medications:

What pharmacy do you use (i.e. CVS, Walgreens, etc.)?

_____

What street is your pharmacy on **OR** what is their phone number?_____

List All Medications: (including over the counter medications)

- ☐ I take no medications
- ☐ See attached medication list (if you've brought your medication list with you)

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES (please list (or check) all that apply):

- ☐ I have no known allergies
- ☐ Penicillin ☐ Lidocaine ☐ Sulfa
- ☐ Adhesive (medical tape) ☐ Latex ☐ Neosporin (or other topical antibiotic)
- ☐ Other _____

Please select one of the following (optional):

Race: ☐ White
☐ Black/African American
☐ Asian American
☐ Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Other _____

Ethnicity: ☐ Hispanic/Latino
☐ Non-Hispanic/Latino

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Please check all that apply:

Have you had your flu shot this year? ☐ Yes ☐ No

Have you had your pneumonia shot? ☐ Yes ☐ No

Smoking History: ☐ Never smoked
☐ Quit: former smoker
☐ Current Smoker: # packs/day: _____ Total years: _____

Alcoholic beverages: ☐ None
☐ Less than 1 drink per day
☐ 1-2 drinks per day
☐ More than 3 drinks per day

CHARLESTON
DERMATOLOGY

Charleston Dermatology, PC
Adam Sperduto, MD
Roger Sullivan, MD
Lee Yarbrough, MD

Patient Information

Last Name First Name MI

_____

Date of Birth Age Gender

_____

Street Address City, State, Zip Code

_____

Social Security Number _____

Marital Status
- ❑ Married
- ❑ Widowed
- ❑ Divorced
- ❑ Single
- ❑ Other:

Occupation/Retired _____

Employer _____

Patient Contact Information

Phone _____

Email _____

Referred By

_____

Responsible Party Information

Last Name First Name MI

Date of Birth Age Gender

Street Address City, State, Zip Code

Insurance Information

Insurance Co. Name	Policy No.	Group No.	Effective Date	Policy Holder's Name/DOB
Insurance Co. Name	Policy No.	Group No.	Effective Date	Policy Holder's Name/DOB

In Case of Emergency Notify (Other Than Responsible Party)

Name (Address if Possible)	Phone

I authorize the release and disclosure of any or all of my medical and treatment records or report to any other health care provider who may be of assistance. In the opinion of Charleston Dermatology, PC and/or for assisting in any reimbursement or medical benefits to which patient may be entitled. _____ I allow fax transmittal of my medical records, if necessary. _____ I further authorize and request that insurance payments be made directly to Charleston Dermatology, PC should they elect to receive such payment. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

I acknowledge full financial responsibility for services rendered by Charleston Dermatology, PC including those which may not be considered covered by my insurance policy. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I authorize treatment by Charleston Dermatology, PC physicians and personnel.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

_____ _____

Patient (Guardian) Signature Date

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PATIENT CONTACT INFORMATION SHEET

Patient Name: _____

Social Security Number: _____-____-_____

Any physician, staff, employee or representative of Charleston Dermatology, PC has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize Charleston Dermatology, PC to contact me via:

□ Phone _____

□ Text Message _____

□ Email _____

Please check below where we have your permission to leave a confidential voice mail (e.g. lab or test results, prescription information). Leave the space(s) blank if you do not wish to receive voice mails.

□ Home _____ □ Cell _____ □ Other _____

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Notice of Privacy Practices Acknowledgement Form

ACKNOWLEDGEMENT OF RECEIPT:

I have received a copy of the Notice of Privacy Practices. I have read, understand and agree to the provisions of this form:

☐ I decline to retain a personal copy of the Notice of Privacy Practices

_____ Signature

____/____/____ Date