



CHARLESTON DERMATOLOGY

Adam L. Sperduto, M.D. | Roger P. Sullivan, M.D. | Lee C. Yarbrough, M.D.

Ashley Allen, M.D. | Megan Hohenberger, M.D.

Julie Shaheen, PA-C | Chris Buthorn, PA-C | Deb Hewlett, PA-C

Anna Cate Smith, PA-C | Samantha Peters, PA-C | Carleigh Myers, PA-C

Last name First Name MI

Date of Birth Age Male / Female Phone Number

Street Address City, State, Zip Code

*Can we text you? YES NO *Can we leave a detailed voicemail? YES NO

Our practice can text you with benign test results, lab results or prescription information

*Do you consent to benign test results , lab results or prescription information via text message? YES NO

Please list your email address if we can email you

RESPONSIBLE PARTY INFORMATION

- if not patient -

Last name First Name MI

Date of Birth Relationship Male / Female Phone Number

Street Address - if different than patient - City, State, Zip Code

IN CASE OF EMERGENCY

Last name First Name

Phone Number Relationship

↔ **PLEASE SEE BACK SIDE** ↔



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Last Name

First Name

Date of Birth

Are you: (for females only) Trying to conceive Pregnant Breastfeeding None

Have you ever had skin cancer? (please check all that apply)

None Basal cell carcinoma Squamous cell carcinoma Melanoma skin cancer

Do you have a family history of melanoma skin cancer in a first degree relative?

No Yes, please circle all that apply: Parents Sibling Child

Do you: Smoke tobacco products Vape Drink alcohol: how many drinks per week? _____

Ages 11-13 years old, have had: MMR TDAP Gardasil

Over the age of 65, have you had a pneumonia vaccine? No Yes, date received _____

Medical History (please check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Coronary artery disease |
| <input type="checkbox"/> History of melanoma | <input type="checkbox"/> Immunocompromised | <input type="checkbox"/> History of stroke |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Lymphoma/ Leukemia | <input type="checkbox"/> Atrial fibrillation |
| <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Autoimmune disease (please specify)
_____ | <input type="checkbox"/> Artificial Heart Valve |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bone marrow transplantation | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer (please specify)
_____ | <input type="checkbox"/> Watchman |
| <input type="checkbox"/> High cholesterol | | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Thyroid Disease (please specify)
_____ |
| <input type="checkbox"/> Hepatitis or liver disease | | |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anxiety and/or Depression | <input type="checkbox"/> Other (please specify)
_____ |

↔ **PLEASE SEE BACK SIDE** ↔

Allergies (please check all that apply)

- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Neosporin/topical antibiotic |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Adhesive (medical tape) | _____ |

Past Surgical History (please list your surgical history)

- None Please see attached list

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications

- None Please see attached list

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy

Name and Street _____

Primary Care Provider

Name _____

X _____
Signature Date