

Dermatology Center of Williamsburg

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IF SOMETHING DOES NOT APPLY TO YOU SIMPLY STATE N/A, NOT APPLICABLE. PLEASE BE AS ACCURATE AS POSSIBLE IN ORDER FOR DR. CORVETTE TO DIAGNOSE APPROPRIATELY.

THANK YOU FOR YOUR PATIENCE!

1. Do you have a history of skin cancer? (Basal Cell, Squamous Cell, or Melanoma) Starting with the most recent, please list the location on your body and what type of cancer was removed

2. Have you been hospitalized or had surgery? Please explain the reason for your hospitalization.

3. Any Medical Diagnosis 4. Current medications 5. Any allergies to medications

_____	_____	_____
_____	_____	_____
_____	_____	_____

6. What is the **first** and **last name** of your **Primary Care Physician**? At which offices(s) are you seen?

Address and Phone number: _____

Do you drink alcohol?	YES	NO	Do you smoke?	YES	NO
Do you exercise regularly?	YES	NO	Are you an outdoors person?	YES	NO
Do you use sunscreen daily?	YES	NO	Do you have a history of cold sores?	YES	NO
Have you used Accutane for acne?	YES	NO	Are you being treated by an Allergist?	YES	NO
Have you ever had abnormal scarring?	YES	NO	Do you have any contact allergies?	YES	NO
Do you have a history of chemotherapy or radiation?	YES	NO			

7. Please check **all** that apply. Does anyone in your family have a history of:

Eczema_____	Psoriasis_____	Hay fever_____
Allergies_____	Asthma_____	Lupus_____

IN THE EVENT YOU NEED SURGERY, PLEASE ANSWER THE FOLLOWING QUESTIONS AND VERBALLY INFORM THE DOCTOR AND MEDICAL ASSISTANTS IF YOU ANSWER YES TO ANY OF THE QUESTIONS:

- Do you take antibiotics prior to dental work for medical conditions? YES NO _____
- Do you take aspirin routinely? YES NO Why? _____
***NEVER STOP** your aspirin prior to a surgery Dr. C performs, **unless** you have the permission of your Primary Physician.
- Do you have a pacemaker? YES NO Type_____
- Do you have HIV? YES NO Year acquired?_____
- Do you have a history of hepatitis? YES NO Year acquired?_____
- Please circle: Are you allergic to: Skin numbering medication? Bacitracin ointment? Iodine? Tape/Band-Aids? Other?_____

Please make sure that the staff is made aware of any changes in the information listed above. It is imperative that we have complete and accurate records of your medical history.

PATIENT PRINTED NAME _____

SIGNATURE _____ DATE _____