Print Form to Sign & Submit

Dermatology Center of Williamsburg
5335 Discovery Park Blvd., Suite A
Williamsburg, VA 23188

Dermatology Center of Williamsburg

Phone: 757-645-3787
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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.

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.

Please list:

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)

7. Please provide: Pharmacy Name, Location and Number.

Do you drink alcohol? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No

Do you use sunscreen daily? ◯ Yes ◯ No

Have you used Accutane for acne? ◯ Yes ◯ No

Have you ever had abnormal scarring? ◯ Yes ◯ No

Do you smoke? ◯ Yes ◯ No

Are you an outdoors person? ◯ Yes ◯ No

Do you have a history of cold sores? ◯ Yes ◯ No

Are you being treated by an Allergist? ◯ Yes ◯ No

Do you have any contact allergies? ◯ Yes ◯ No

Do you have a history of chemotherapy or radiation? ◯ Yes ◯ No

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

1. Do you take antibiotics prior to dental work for medical conditions? ◯ Yes ◯ No

2. Do you take aspirin routinely? ◯ Yes ◯ No If yes, why?

NEVER stop aspirin prior to surgery , unless you have the permission of your Primary Physician.

3. Do you have a pacemaker? ◯ Yes ◯ No

4. Do you have HIV? ◯ Yes ◯ No Year acquired _____

5. Do you have a history of hepatitis? ◯ Yes ◯ No Year acquired _____

6. Are you allergic to: (Please check all that apply.) ☐ Skin numbing 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 _____

RESPONSIBLE PARTY/PATIENT SIGNATURE _____ DATE_____

Revised 10/08
Interactive 1/10

*****Please print to sign and date.*****