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

Phone: (757) 645-3787
Fax: (757) 645-3774

Dermatology Center of Williamsburg

MEDICAL HISTORY page 1 of 2

Patient Name_____

1. Please tell us who referred you to the Dermatology Center of Williamsburg? _____
2. When was your last skin cancer exam performed by a Dermatologist MD/PA? _____
3. Name of your previous Dermatologist/location and date seen? _____

List all of your **SKIN CANCERS**, exact **BODY LOCATION**, **YEAR TREATED**, **HOW TREATED** (ED&C, Excision, Radiation, Mohs, prescription cream) **WHO TREATED**?

1 _____
2 _____
3 _____
4 _____
5 _____

Do you have a family history of melanoma? ○ Yes (Family member _____) ○ No
Do you have a **pacemaker or defibrillator**? ○ Yes ○ No
Have you been told by your cardiologist or orthopedic surgeon that you need to be on antibiotics prior to surgery?
○ Yes ○ No Why?/When? _____

List ALL of your **MEDICAL DIAGNOSES** including history of cold sores/location (herpes simplex), HIV, hepatitis, abnormal scarring/Keloids, joint replacements/**DATE** replaced, valve replacement/DATE

1 _____
2 _____
3 _____
4 _____
5 _____

List ALL of your **PRESCRIPTION AND NONPRESCRIPTION OTC MEDICIN**E.
Include ALL supplements and herbal medications:

1 _____
2 _____
3 _____
4 _____
5 _____

List the blood thinners you take. (ex. aspirin, fish oil, pain relievers, plavix, Coumadin, Eliquis, Pradaxa, Xarelto, or other) **Why do you take this drug?**

1 _____
2 _____

**Please let our staff know if you would like a courtesy consultation with our Master Aesthetician, Tracey Ovitt.
Her services include **laser hair removal, intense pulsed light therapy, waxing, and more!****

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Tell us **ALL** of your **ALLERGIES** and **TYPE OF REACTION** (rash, hives, difficulty breathing) to medications (including lidocaine, local anesthetics, iodine, epinephrine), latex, adhesives, and local anesthetics

1 _____
2 _____
3 _____
4 _____
5 _____

Primary Care Provider and LOCATION:

_____

NAME and **SPECIALTY** of all **DRS/NP/PA** providers you see:

1 _____
2 _____
3 _____
4 _____
5 _____

LOCAL PHARMACY AND MAIL ORDER PHARMACY with **ADDRESS** include **street and city**, CIRCLE the pharmacy you would like DCW to send your prescriptions.

1 _____
2 _____

Have you ever had plastic surgery or Botox? ○ Yes ○ No
Dr. Corvette performs Botox Injections; if you would like a courtesy consult; please let our staff know.
Have you received the seasonal flu vaccine this past year? ○ Yes (Date received _____) ○ No
Have you ever received the pneumonia PNEUMOVAX vaccine? ○ Yes ○ No
Do you have any history of tobacco use? ○ Yes ○ No
Have you ever had a sunburn? ○ Yes ○ No
Have you ever used a tanning bed? ○ Yes ○ No

We value you as our patient at the Dermatology Center of Williamsburg!
We consider you, our staff, and all of your providers as a solid team.
Communication, trust, and treating each patient and staff member with dignity and respect is expected.

I give DCW permission to fax my medical notes to my treating physicians.
If I am referred to a Physician by DCW MD/PA for a surgical excision of a skin cancer; it is my responsibility to contact DCW if I do not have an appointment within 2 weeks of the referral.
If I had a biopsy performed by this office and I have not received the results of the biopsy within 2 weeks, it is my responsibility to contact this office for the results of the biopsy within 2 weeks of the date biopsy performed.
It is my responsibility to update my medical information at each DCW visit.
We appreciate you and we will give you the best care possible.

PATIENT PRINTED NAME _____ DATE OF BIRTH_____
RESPONSIBLE PARTY/PATIENT SIGNATURE_____ DATE _____