PRESTON
DERMATOLOGY + SKIN SURGERY

Patient Name: _____ **DOB**: _____ **Date**: _____

Pharmacy Name/Address:_____

Personal Past Medical History or Current Disease(s):

Skin Cancer/Melanoma	Y	N	HIV/ AIDS	Y	N
Actinic Keratosis	Y	N	Hepatitis C / Liver Disease	Y	N
Thyroid Disorders	Y	N	Cancer (other than skin cancer)	Y	N
Diabetes	Y	N	Psoriasis	Y	N
Kidney Disease	Y	N	Childhood eczema	Y	N
High Blood Pressure	Y	N	Seasonal allergies or hay fever	Y	N
Heart Attack or Stroke	Y	N	Asthma	Y	N
Artificial Joint/Valves	Y	N	Keloid	Y	N
Pacemaker/ Defibrillator	Y	N	Anesthetic Complications	Y	N
Organ/Marrow transplant	Y	N	Autoimmune Disease	Y	N
Are you PREGNANT	Y	N	Are you breastfeeding	Y	N

If you answered **YES** to any of the above, please explain: _____
Other major medical illnesses/surgeries:_____

Have you ever had a blistering sun burn? YES NO
Do you wear sunscreen every day? If so what SPF? _____ YES NO
Have you ever been in a tanning bed? YES NO

Smoking Status: Current every day smoker Former smoker Never Smoker
IV Drug Use: YES NO
IV Drug use within past 12 months: YES NO
How Many times in the past year have you had 5 or more drinks in a day, or 4 or more drinks in a day for women? (0-365): _____

For patients 65 and older ONLY:
-Vaccination Status: Have you received a pneumonia vaccination? YES NO
-Do you have a health care proxy in the event you are unable to make your own medical decisions? YES NO
If Yes, designee's name and phone number: _____
-Do you having a living will? YES NO
-Which statement best reflects your wishes on advanced care recommendations? Please circle below

- **Full Cardiopulmonary Resuscitation**: I want full cardiopulmonary resuscitation efforts made
- **Do Not Intubate**: I do not wish to have a breathing tube, even if it is necessary to save my life.
- **Do Not Resuscitate**: if my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:

_____

_____

MEDICATION OR ADHESIVE ALLERGIES:

_____