



DR.  
MONICA  
MCCRARY

**Patient Information**

Prefix: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Nickname: \_\_\_\_\_ Suffix: \_\_\_\_\_ SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Occupation: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Name of Patient's primary care Provider (Primary Medical Doctor): \_\_\_\_\_

If possible, please provide this person's Phone # and Fax #:

Pharmacy Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship: \_\_\_\_\_

Spouse Full Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Care Taker Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Patient Home Number: \_\_\_\_\_ Patient Work Number: \_\_\_\_\_ Patient Mobile Number: \_\_\_\_\_

Is it ok to leave detailed message:  Yes  No

Preferred phone number to be contacted on:  Home  Work  Mobile

Email Address: \_\_\_\_\_

**Guarantor Information**

Guarantor Contact Information:  Same as Patient

Patients Relationship to Guarantor: (please check)  Self  Spouse  Child  Other \_\_\_\_\_

Guarantor Last Name: \_\_\_\_\_ Guarantor First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Consent for Release of Medical Information to Family Members or Personal Representative

Yes, The Practice May Discuss:

Medical Condition/ Treatment  Appointments  Prescriptions  Financial  Pathology and/or Lab Results with the following person(s)

Please list Authorized Person(s) Below

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical Conditions

**Please mark the skin condition that you or your family / blood relatives have OR have had**

Condition	Self	Family	Relation	Condition	Self	Family	Relation
High blood pressure				Congestive heart failure			
Asthma/hay fever				Mitral Valve Prolapse			
Liver Disease				Hyperlipidemia			
Kidney Disease				Atrial Fibrillation			
Depression/psychiatric				Multiple Sclerosis			
Diabetes				Thyroid Disease			
Tuberculosis				Hepatitis C			
Autoimmune disease				HIV / AIDS			
Gastrointestinal disease				Bleeding Disorder			
Arthritis				Cancer / Lymphoma			
Pacemaker				Blood Thinner			

### MEDICATIONS:

Please list any current prescription and "over-the-counter" medications **AND** any alternative or complementary therapies **AND** supplements that you use or take. Please include the name of the product, how much, and how often you use or take it. Use the back of this sheet to continue if necessary.

MEDICATION #1	How much (dose)?	How often (frequency)?
MEDICATION #2	How much (dose)?	How often (frequency)?
MEDICATION #3	How much (dose)?	How often (frequency)?
MEDICATION #4	How much (dose)?	How often (frequency)?
MEDICATION #5	How much (dose)?	How often (frequency)?

## Skin History

Do you sunbathe?  Yes  No      Have you used tanning beds?  Yes  No      History of Skin Cancer:  Yes  No

Date of last skin cancer: \_\_\_\_\_ Date of last Flu shot: \_\_\_\_\_ Date of last Pneumococcal shot: \_\_\_\_\_

**Please mark the skin condition that you or your family / blood relatives have OR have had**

Condition	Self	Family	Relation	Condition	Self	Family	Relation
Actinic Keratosis				Psoriasis			
Basal Cell Carcinoma				Difficulty with wound healing			
Squamous Cell Carcinoma				Difficult with skin infections			
Melanoma				Hives			
Atypical / Dysplastic Mole				Eczema / Rashes			
Keloid / Scars				Rosacea			
Acne / Accutane				Other Skin Conditions			

Females only: Are you pregnant?  Yes  No      Are you nursing?  Yes  No      Do you take birth control?  Yes  No

Do you smoke?  Never     Current       Former, Total years smoking \_\_\_\_\_

Do you drink alcohol?  None       Less than 1 drink per day       1-2 drinks per day       3 or more drinks per day

Current Medications:  None       See attached list OR please list below

Patient MEDICATION Allergies:  No Known Drug Allergies

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_