Cibolo Creek
DERMATOLOGY GROUP

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:** _____

PAST MEDICAL HISTORY

Page#

Patient's Name

MEDICAL CONDITIONS	SURGERIES	HOSPITALIZATION	ANY OTHER CONDITIONS