GOODMAN DERMATOLOGY
and Mohs Surgery

NAME: ____ **DOB:** ________________

ADDRESS: ____

CITY: _____________________________ **STATE:** ___________ **ZIP:** _______________

PHONE NUMBER: ______________________ **EMAIL:** ____________________________

- ☐ **HOME**
- ☐ **MOBILE**
- ☐ **WORK**

Can we leave a detailed message?

- ☐ **YES**
- ☐ **NO**

EMERGENCY CONTACT NAME: ____

PHONE NUMBER: ____

INSURANCE INFORMATION:

Primary Insurance**:** ____

Policy Holder**:** ____

Policy Number**:** ____

Member ID**:**____

Secondary Insurance Information:____

Policy Holder:____

Policy Number: ____

Member ID:____

PAST MEDICAL HISTORY:

- ☐ None
- ☐ Arthritis
- ☐ Asthma
- ☐ Chronic obstructive lung disease
- ☐ Depressive disorder
- ☐ Diabetes melitius
- ☐ Elevate blood pressure
- ☐ End-stage renal disease
- ☐ H/O: hypertension
- ☐ HIV
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of the colon
- ☐ Radiation therapy treatment management
- ☐ SARS-CoV 2 mRNA vaccine
- ☐ Transplantation of bone marrow
- ☐ Other

PAST SURGERIES:

- ☐ None
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ History of colectomy
- ☐ History of tissue graft heart valve replacement
- ☐ Mechanical heart valve replacement
- ☐ Splenectomy
- ☐ Surgical biopsy of skin
- ☐ Total replacement of left hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of right knee joint
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ Other

SKIN CONDITIONS:

- ☐ None
- ☐ Acne
- ☐ Actinic keratosis
- ☐ Astearosis cutis
- ☐ Basal cell carcinoma of skin
- ☐ Contact dermatitis
- ☐ Dysplastic nevus of skin
- ☐ Eczema
- ☐ H/O: asthma
- ☐ H/O: hayfever
- ☐ Malignant melanoma
- ☐ Pruritus of skin
- ☐ Psoriasis
- ☐ Squamous cell carcinoma
- ☐ Sunburn of second degree
- ☐ Other

SKIN PROTECTION:

Do you wear sunscreen?

- ☐ YES
- ☐ NO

Do you tan in a tanning salon?

- ☐ YES
- ☐ NO

FAMILY HISTORY OF MELANOMA:

- ☐ YES
- ☐ NO

If you answered yes, which family member? ____

MEDICATIONS: ***please list or provide current medication list***

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

ALLERGIES: ***check box if no known drug allergies or list***

- ☐ No known drug allergies

____

SOCIAL HISTORY:

What is your tobacco usage?

- ☐ Current every day smoker
- ☐ Current some day smoker (tobacco)
- ☐ Current some day smoker (cigarette)
- ☐ Former smoker
- ☐ Never smoker

Do you use vaping products?

- ☐ YES
- ☐ NO

Do you use smokeless tobacco?

- ☐ None
- ☐ Dip
- ☐ Chew
- ☐ Snuff
- ☐ Nicotine gum
- ☐ Nicotine patch
- ☐ Other

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ >5

Do you use recreational drugs?

- ☐ YES
- ☐ NO

For patients 65 and older:

Have you received a pneumonia vaccination on or after your 60th birthday?

- ☐ 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: ____

Designee's phone number: ____

Do you have a living will?

- ☐ YES
- ☐ NO

Which statement best reflects your wishes on advanced care recommendations?

- ☐ Do Not Intubate: I do not wish to have a breathing tube, even if 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.
- ☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.