Welcome to Carolina Skin Surgery Center

2615 E. 7th St. Charlotte, NC 28204 ~ Phone: 704-295-0000 ~ Fax: 704-295-0005 ~ Marc Carruth, M.D.

Today's Date: _____

Full Name: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Phone # (Home): _____ Phone # (Cell): _____ Phone # (Work): _____

Preferred phone # to contact: ☐ Home ☐ Cell ☐ Work **Is it okay to leave a detailed message?** ☐ **Yes** ☐ **No**

Emergency Contact & Release of Health Information:

Emergency Contact Name: _____ Relationship: _____

Cell Phone Number: _____

Do you give our office permission to discuss medical & billing information with your Emergency Contact? ☐ Yes ☐ No

Do you give our office permission to discuss medical & billing information with other Family Members? ☐ Yes ☐ No

If yes: Name: _____ Name: _____

Contact #: home_____ cell_____ Contact #: home_____ cell_____

Relationship: _____ Relationship: _____

Patient signature: _____ *A signature is required for any information to be released to the above named*

Insurance Information:

Primary Insurance: _____ ID#: _____

Who is the Primary Policy Holder? ☐ Self ☐ Other- fill in Name and Date of Birth of Primary Policy Holder _____

Secondary Insurance: _____ ID#: _____

Tertiary Insurance: _____ ID#: _____

Please bring your insurance cards to your appointment so we can scan them into our system.

Care Team Information:

Referring provider: _____ Primary Care Provider: _____

Phone Number: _____ Phone Number: _____

Additional provider(s) name: _____

Pharmacy Information:

Name: _____ Phone Number: _____

Pharmacy Address: _____

Please complete these forms and return to our office 1 week prior to your scheduled appointment.

Name: _____ **Date of Birth:** _____

Past Medical History:

Select any of the following medical conditions you currently have or have had in the past:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Sleep Apnea
  Do You Use a CPAP Mask ?
  Yes _____ No ____
- ☐ Stroke
- ☐ Heart Attack
- ☐ NONE
- ☐ Other

_____
_____
_____

Have you received the flu vaccine this year? ☐ Yes ☐ No

If you are over 65, have you had the pneumonia vaccine? ☐ Yes ☐ No

Past Surgical History:

Do you have any of the following? Check if applicable.

☐ Pacemaker ☐ Defibrillator ☐ Artificial Heart Valve Type: _____ Year Performed: _____

☐ Artificial Joint: Which joint(s) & what year(s) performed: _____

Have you had any surgeries on the following organs?

- ☐ Appendix (Removal)
- ☐ Bladder (Removal)
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon Resection
- ☐ Colon: Colostomy
- ☐ Gallbladder (Removal)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Kidney: Kidney Transplant
- ☐ Kidney (Removal)
- ☐ Liver (Removal)
- ☐ Liver: Liver Transplant
- ☐ Ovaries (Removal)
- ☐ Pancreas (Removal)
- ☐ Prostate Biopsy
- ☐ Prostate (Removal)
- ☐ Spleen (Removal)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Other:_____

Skin Disease History:

Have you had any of the following?

- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Squamous Cell Skin Cancer
- ☐ Other_____
- ☐ None

Do you tan in a tanning salon?

◯ Yes ◯ No

Do you have a family history of Melanoma?

◯ Yes ◯ No

If yes, which relative?

☐ Mother	☐ Uncle	☐ Other:
☐ Father	☐ Aunt	_____
☐ Sister	☐ Nephew	_____
☐ Brother	☐ Niece	
☐ Daughter	☐ Grandmother	
☐ Son	☐ Grandfather	

Do you wear sunscreen?

◯ Yes ◯ No

Family History of Skin Cancer:

Please include only first-degree relatives (Ex: Mother, Father, Grandparents):

_____
_____

Medications:

List all current medications (***including the dose and frequency***):

_____
_____
_____
_____

Allergies:

List all allergies and reactions if known:

_____
_____
_____

Social History:

Smoking Status (please choose one):

- ☐ Current daily smoker
- ☐ Current occasional smoker
- ☐ Former smoker
- ☐ Never smoker

Number of Packs Per Day: _____

Start Smoking:

- Date: _____

Quit Smoking:

- Date: _____

Total Years Smoking: _____