M.A. STAWISKI, M.D.
DERMATOLOGY

HISTORY

Date: _____
Update: _____
Update: _____

NAME: _____ Date of Birth: _____

TELEPHONE NUMBER (to reach you with information or results): _____

May we leave medical information or test results on your answering machine? ☐ YES ☐ NO

Primary Care Physician: _____

MEDICAL HISTORY:

1. Major Illnesses / Hospitalizations / Chronic conditions: _____

_____

2. Surgeries: _____

_____

3. Do you have any of the following (check all that apply)

☐ Hypertension (High Blood Pressure) ☐ Diabetes ☐ Heart Disease (Murmur)

☐ Pacemaker ☐ Artificial Joints ☐ Artificial Heart Valves / Stents

Explain checked Items: _____

_____

MEDICATIONS (Include creams and supplements)	Name	Dose	How Often
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

ALLERGIES TO MEDICATIONS: _____

Allergy to latex: ☐ Yes ☐ No Allergies to foods or environment? _____

Do you need to take antibiotics prior to dental or surgical procedures? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How much? _____ Do you drink alcohol? ☐ Yes ☐ No How much? _____

SKIN HISTORY: (List onset, duration, any treatments)

1. General Problems: _____
2. Skin cancer history: _____
3. Severe sun exposure: _____
4. Chronic X-ray treatment: _____
5. When exposed to sunlight, do you: ☐ Burn ☐ Burn-tan ☐ Tan Only

FAMILY MEDICAL HISTORY: (List any medical problems /conditions of family members)

1. Mother: _____
2. Father: _____
3. Children / Siblings: _____

Patient Signature: _____ Date: _____