



# DERMATOLOGY

at The Eye Associates

---

**Paul Stevenson, DO, FAOCD**

---

**John Swencki**  
Chief Executive Officer

Thank you for choosing Dermatology at The Eye Associates as your skin care provider. We appreciate the opportunity to provide you with professional care.

Enclosed you will find a Medical History Questionnaire and medication page that you will need to complete prior to your visit and bring with you to your appointment.

Please arrive 15 minutes prior to your appointment time to allow us to take care of any last minute details.

If you have any questions, please do not hesitate to give us a call at 941-794-DERM(3376) or toll free 1-877-816-3376.

---

West Bradenton Office & Surgery Center  
East Bradenton Office & The Optical Gallery  
Ellenton Office & The Optical Gallery  
Sarasota Office, The Optical Gallery & Dermatology  
Venice Office & The Optical Gallery  
Sun City Office & The Optical Gallery  
Dermatology & Hearing Office

- 6002 Pointe West Blvd, Bradenton, FL 34209
- 7230 55th Avenue East, Bradenton, FL 34203
- 7915 US Hwy 301 N, Suite #101, Ellenton, FL 34222
- 2111 Bee Ridge Road, Sarasota, FL 34239
- 250 South Tamiami Trail, #103, Venice FL 34285
- 3894 Sun City Center Blvd, Sun City Center, FL 33573
- 2101 61st St W, Bradenton, FL 34209

- 941-792-2020
- 941-758-1916
- 941-729-2020
- 941-923-2020
- 941-493-3763
- 813-634-2020
- 941-794-3376

**[www.Derm4Life.com](http://www.Derm4Life.com)**

**Toll Free: 1-877-816-3376**

# Dermatology at The Eye Associates

Name \_\_\_\_\_ DOB \_\_\_\_\_ Acct# \_\_\_\_\_ Date \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ City/State \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Last skin exam with \_\_\_\_\_

Do you **currently** have any problems in the following areas?  
If YES, please provide additional information below

## SOCIAL HISTORY:

Current Occupation \_\_\_\_\_

Marital Status  single  married  widowed

Education:  high school  vocational  college

Do you use tobacco?  No  Yes How long? \_\_\_\_\_

Cigarettes  Yes  No Cigars  Yes  No

Pipe  Yes  No Frequency \_\_\_\_\_

Chewing  Yes  No Snuff  Yes  No

Frequency \_\_\_\_\_

PLEASE LIST MEDICATIONS ON  
PAGE 2

List any **allergies** to medications:  
(*prescription and/or over the counter*)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## FAMILY HISTORY OF: If yes list relative

Melanoma  No  Yes \_\_\_\_\_

Have you had any skinsurgery or been diagnosed with  
any skin disease?  No  Yes Provide information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you require antibiotics prior to surgery or dental  
work?  Yes  No

When exposed to sun, do you  Tan  Burn & Tan  
 Burn?

Are you allergic to Latex?  Yes  No

List any **surgeries** you have had (heart surgery,etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

	YES	NO
<b>High Blood Pressure</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Heart Problems</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Diabetes</b> (year diagnosed _____)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Major Cancer</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Kidney Disease</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Liver Disease</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Bleeding Tendencies</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Breathing Problems</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurologic Disease</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Rheumatoid Disease</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hepatitis A, B, or C</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>HIV/Aids</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Arthritis</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Allergies</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Stroke</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Asthma</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Thyroid</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ulcer</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Depression</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin Cancer</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Mitral Valve Prolapse</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Females</b> Are you pregnant? Nursing?	<input type="checkbox"/>	<input type="checkbox"/>

Details \_\_\_\_\_

## PHARMACY INFO

Name \_\_\_\_\_

Phone # \_\_\_\_\_

Address \_\_\_\_\_

Mail order \_\_\_\_\_

For Office Use Only

Date updated \_\_\_\_\_ Init. \_\_\_\_\_

Date updated \_\_\_\_\_ Init. \_\_\_\_\_

Date updated \_\_\_\_\_ Init. \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Acct# \_\_\_\_\_ Date \_\_\_\_\_

List ALL medications, INCLUDING Over the counter medications, Herbals and vitamins that you currently take:

<b>Medication Name</b> (prescriptions, herbals, vitamins, over the counter meds, etc.)	<b>Strength</b> (mg, tsp, tablet, etc.)	<b>Directions</b> (times per day or week, as needed, etc)	<b>Medication is taken</b> (oral, injection, topical, etc.)