DERMATOLOGY
at The Eye Associates

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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.

Dermatology at The Eye Associates

Name _____ DOB _____ Acct# _____ Date _____

Primary Care Physician _____ City/State _____ Phone # _____

Emergency Contact _____ Relationship _____ Phone #_____

Last skin exam with _____

SOCIAL HISTORY:

Currrent 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.)

_____

_____

_____

_____

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

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

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:

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