MEDICAL HISTORY

Patient's Name:_____ **Today's Date:** _____

Reason for today's visit: _____

Are you allergic to any medications? ☐ **YES** ☐ **NO** **If yes, please list:**

1._____ **2.**_____ **3.**_____

List all medications you are currently taking including prescribing Physician, milligrams, micrograms, strength, quantity, etc.:

1._____ **2.**_____ **3.**_____

4._____ **5.**_____ **6.**_____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Wheezing	☐	☐
Shortness of breath	☐	☐
Morning Cough	☐	☐
Vascular:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Pacemaker	☐	☐
Mitral Valve Prolapse	☐	☐
Do you need pre-medication?	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Stomach	☐	☐
Bowel	☐	☐
Glaucoma	☐	☐
Arthritis/Joint Deformity	☐	☐
Musculoskeletal	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐
Hepatitis or Yellow Skin	☐	☐

Type _____

Do you drink alcohol? ☐ **Yes** ☐ **No If Yes** _____ **per day**
Do you use IV drugs? ☐ **Yes** ☐ **No If Yes, what?**_____ **How much?**_____
Have you had or have you been exposed to HIV (AIDS)? ☐ **Yes** ☐ **No**
Have you ever had dental anesthesia (Novocaine)? ☐ **Yes** ☐ **No**
Any bad reaction? ☐ **Yes** ☐ **No**

Skin:
When you are exposed to sun do you: ☐ **Tan only** ☐ **Tan and burn** ☐ **Burn**
Have you ever had skin cancer? ☐ **Yes** ☐ **No If yes, site** _____**what type?**_____
Has anyone in your family had skin cancer? ☐ **Yes** ☐ **No If yes, who**_____**what type?**_____
Do you have a history of any specific skin diseases? ☐ **Yes** ☐ **No**
If yes, please list:_____
List any other disease or condition we should know about: _____
List surgical procedures you have had in the last 6 months:_____

Smoking status: ☐**current every day smoker** ☐**current some day smoker** ☐**former smoker** ☐**never smoker**

B. Do you bleed easily? ☐ **Yes** ☐ **No**
C. (Women) Are you pregnant? ☐ **Yes** ☐ **No** **If yes, Due Date:**_____
D. Do you have artificial joint(s)? ☐ **Yes** ☐ **No** **Do you need pre-meds?** ☐ **Yes** ☐ **No**
E. What is your occupation? _____
F. What are your hobbies? _____

Completed by: ☐ **Patient** ☐ **Parent** **Initials:** _____

Signed by Physician: _____ **Date:** _____

MANHASSET DERMATOLOGY, P.C.
JOHN S. WALCZYK, M.D., F.A.A.D.
1165 Northern Blvd., Suite 405
Manhasset, NY 11030

E-PRESCRIBING

Name: _____ Date of Birth: _ ___/____/____

ePrescribing is an electronic way to generate prescriptions through an automated data-entry process utilizing e-Prescribing software and a transmission network which links to participating pharmacies. The privacy of your personal health information contained in all your prescriptions, whether written or electronic, is protected by a federal law and state laws. The federal law is the Health Insurance Portability and Accountability Act (HIPAA). HIPAA requires that your personal health information be shared only for the purpose of providing you with clinical care. Electronic prescriptions meet this requirement.

Patient benefits:

- **Fewer errors that arise due to difficulties in reading or understanding handwritten prescriptions or unclear phone calls.**
- **Less chance of adverse drug reactions**
- **Fewer trips to drop off prescriptions at the pharmacy**
- **A safe, faster, easier way to get your prescriptions filled**

Patient consent:

I agree that Manhasset Dermatology, P.C. may ePrescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. I understand that this consent will remain in effect unless revoked in writing.

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____

Relationship to Patient: _____