DEPARTMENT OF DERMATOLOGY

Stony Brook Medicine

Dear Patient,

We welcome you to Stony Brook Dermatology Associates. It is important not to rush through these forms since important (requested) data such as your medical history must be accurate and thorough. If you are unsure of any section, leave it blank and we will assist you when you arrive.

Please remember to bring your completed forms, your insurance card so that we can scan it into your electronic medical record and your referral (if applicable). Insurance referrals authorize payment for medical services & if you are insured with a carrier that requires one, it is your responsibility to obtain it & confirm that it has either been submitted electronically by your primary care physician (PCP) and or received in the office. If you need the ID# for the dermatologist you will be seeing here, we are more than happy to provide you with the information you need to ease the process. **All (paper) referrals should be sent to fax# 631-638-4220.**

Once you have checked in with reception you will be seen by billing to verify your insurance eligibility and copayment responsibility. *We respectfully request a minimum 24hr. advance notice if you need to cancel or reschedule to avoid a "No Show" fee.* We understand that you may have changes to your own schedule however, our goal is to maximize appointment availability to ensure that all patients on our wait list can avail themselves of unexpected appointment openings.

If you have any questions prior to your visit, please feel free to contact us @ 631-444-4200 and we will be happy to assist you.

Sincerely,

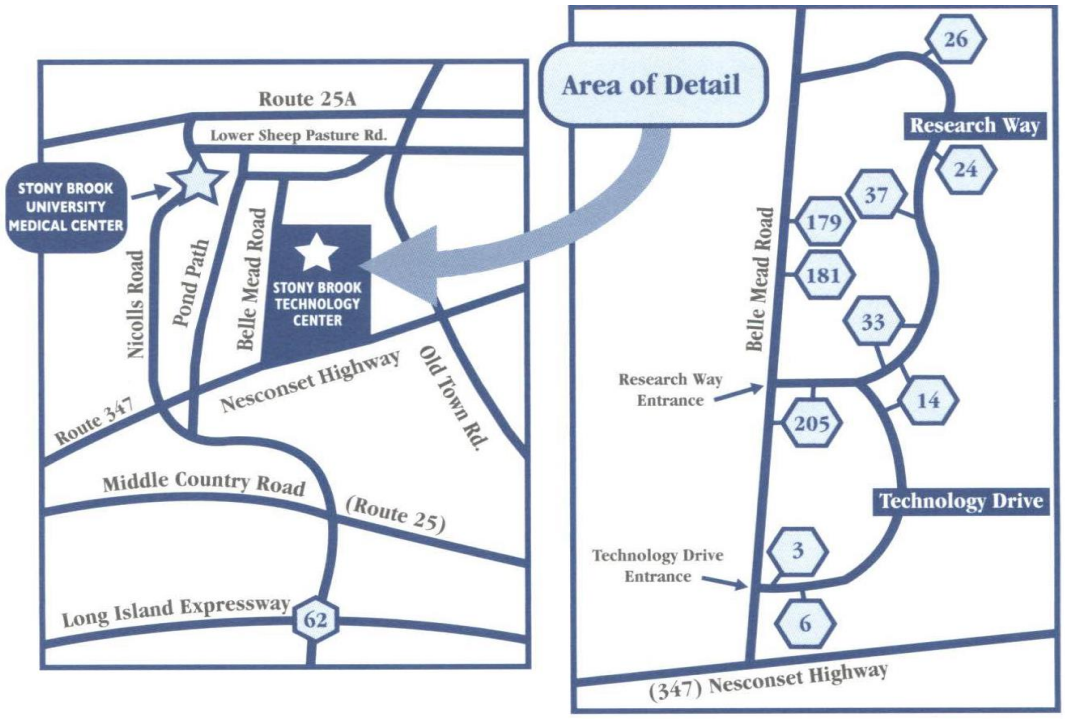
Julie Bouziotis
Practice Manager

Stony Brook Dermatology Associates
181 Belle Mead Road Suite #5
East Setauket, New York 11733-9221
www.stonybrookphysicians.com
Phone: 631-444-4200 Nursing Fax: 631-444-4276 Reception Fax: 631-638-4220

a Map for your convenience

Directions to our office can be obtained by calling our main number @ 631-444-4200 and pressing option 4.

- **From the LIE (Long Island Expressway)** take exit 62 and follow signs for Route 97 N Nicolls Road. Continue on Nicolls Road to Route 347 (Nesconset Highway) and make a right. At the 3rd traffic light make a left onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.
- **From the NS (Northern State Parkway)** please follow it to the end & follow signs for Route 347 (Nesconset Highway). Cross over Nicolls Road and make a left at the 3rd traffic light onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.
- **From Route 347 (Nesconset Highway) traveling West** make a Right onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.
- **From Route 347 (Nesconset Highway) traveling East** you will cross over Nicolls Rd. & make a left onto Belle Mead Rd. which is the 3rd traffic light. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.
- **From 25A traveling East** make a Right onto Nicolls Rd. traveling South and continue to Route 347 (Nesconset Highway) and make a Left. At the 3rd traffic light make a Left onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.
- **From 25A traveling West** make a Left onto Nicolls Rd. traveling South and continue to Route 347 (Nesconset Highway) and make a Left. At the 3rd traffic light make a Left onto Belle Mead Rd. You will be entering Technology Park. Continue on Belle Mead Rd. to #181 & turn right into the parking lot.



Department of Dermatology Stony Brook University
Surgery Consultation History Form

PATIENT NAME: _____ MRN#_____

Who referred you to us?_____
Street Address:_____
City:_____ State_____ Zip code_____
Phone Number_____Fax Number_____

Primary Physician_____
Street Address:_____
City:_____ State_____ Zip code_____
Phone Number_____Fax Number_____
Pharmacy Name_____
Phone Number_____

Reason for Referral/History of Your Problem

For each skin lesion you are referred for, please answer the following:

Lesion 1. Location Right Left_____

Yes No Has it been biopsied?
Yes No Unsure Is it a skin cancer? How long have you had it?_____Months Years
Yes No Is it growing?
Symptoms: (Please circle) bleeds forms a sore rough or scabbed painful itches numbness

If you are presently experiencing **skin pain**, please indicate where? _____

On a scale of 0 to 10 with 0 being the lowest and 10 being the highest, please rate the pain _____

Yes No Has it been treated before? *If Yes*, dates and treatment type
_____
Yes No Has the area been exposed to radiation? *If Yes*, details:
_____

Your Comments_____
_____
_____
Physician Comments_____
_____
_____

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Lesion 2. Location Right Left_____

Yes No Has it been biopsied?
Yes No Unsure Is it a skin cancer? How long have you had it?_____Months Years
Yes No Is it growing?
Symptoms: (Please circle) bleeds forms a sore rough or scabbed painful itches numbness
Yes No Has it been treated before? *If Yes*, dates and treatment type

_____

Yes No Has the area been exposed to radiation? *If Yes*, details:

_____

Your Comments_____

_____

_____

Physician Comments

_____

*For more skin lesions please request an additional form at your consultation visit.

List your daily Medications, Vitamins and any herbal supplements.

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Yes No Do you take: Garlic___ Vitamin E supplement___ Ginkgo___ Ginseng ___?

Yes No Do you take **aspirin**? *If Yes*, why? _____

_____

Yes No Have you been off it before without difficulty? *If Yes*, details

_____

Yes No Do you take **coumadin**? *If Yes*, why? _____

_____

Yes No Have you been off it before without difficulty? *If Yes*, details _____

_____

Yes No **Medication Allergy**? *If yes*, list mediation and describe allergy _____

_____

_____

List major illness(s), and Hospitalizations and date:

_____

_____

_____

_____

Yes No I have (circle): artificial joint , prosthetic heart valve, cardiac stent, cardiac defibrillator

Yes No Do you have a pacemaker?
If Yes, totally dependent on it? **Yes No** (Works as backup when needed)

Yes No I have had: rheumatic heart disease endocarditis

Yes No I routinely take antibiotics with dental work or other procedures.

Comments:_____

_____

_____

Circle all conditions that apply to you:

Constitutional:	None	Fever Weight loss Night sweats
Ear, Nose, Throat:	None	Cold sores Ear Problems
Eye:	None	Difficulty with tearing Change in vision
Cardiovascular:	None	High blood pressure Chest Pain Heart murmur
Respiratory:	None	Difficulty breathing
Gastrointestinal:	None	Hepatitis
Genitourinary:	None	Frequent urination
Musculoskeletal:	None	Weakness
Endocrine:	None	Diabetes (good/poor control)
Neurologic:	None	numbness weakness dizziness
Psychiatric:	None	depression nervousness anxiety
Hematologic:	None	bruise easily
Immunologic:	None	frequent skin or other infections HIV infection swollen lymph nodes Where?_____
Skin:	None	history of precancers other active conditions: _____

_____

Skin Cancer History

Yes No Do you sunburn easily?

Yes No Did you have blistering sunburns as a child?

Yes No Do you or have you used tanning beds? *If yes*, regularly__ occasionally__

Yes No Do you get a lot of sun exposure regularly?

Yes No Do you use sunscreens? *If yes*: regularly__ occasionally__ rarely__ never__

Yes No Have you had a previous skin cancer? *If yes*, type, location, and the physician you see for this_____

Yes No Have you had a melanoma? *If yes* list details _____

_____

_____

_____

Physician Comments: _____

_____

_____

_____

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Family History

Yes No Does skin cancer run in the family? *If yes*, in whom and what type: _____

_____

Social History

Yes No Do you smoke? If yes how much: _____packs per day
Yes No Do you drink alcohol?
Yes No Do you have a history of alcohol or drug abuse?
Occupation: Current or Former_____

_____

We want to thank you for taking your time in providing this important information that will assist us in providing your care!

Please sign here:

_____

Patient Family Member (Relationship to patient)

For Office use only

Reviewed by:_____Date_____
Resident Physician

Yes No Antibiotic prophylactic Cephalexin___ Azithromycin___ Other_____
Yes No **Pre-Operative Clearance**
Reason:_____
Yes No Anticoagulant cessation: Stop 3 days prior to surgery___Contact Physician___
Yes No Labs: CBC, Platelet ct., PT/ INR
Yes No Need for sterile procedure (heart valve replacement)
Yes No Special room accommodations

No Yes Pre-Op instruction sheet reviewed and given to patient
No Yes Digital photo taken
No Yes Sun protection guidelines reviewed.
No Yes Sun screen samples given.

Additional Attending Physician
Comments:_____

_____

I have reviewed the medical history form: _____

Evan Jones M.D. 190314
Kavita Mariwalla, M.D. 190363
Dermatologic and Cosmetic Surgery
Stony Brook University
Phone: 631-444-4200 **Fax:** 631-444-4276