Lala M. Stawowy MD
9150 Huebner Road, Suite 330
San Antonio, TX 78240

History and Intake Form

NAME:_____ **DATE OF BIRTH:**_____

Reason for your visits: _____

_____

How long have you had this problem: _____

Symptoms (How does it bother you): _____

Treatments you have tried: _____

Referred by:

Dr. (Name) _____ Family Member (Name) _____

Friend (Name) _____ Yellow Pages (X) ____

Print Ad _____ Website (X) ____ Other_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
BPH (Benign Prostatic Hyperplasia)
Breast Cancer
Colon Cancer
COPD-Emphysema
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None

Other _____

Past Surgical History: (please circle all that apply)

Appendix: Removed
Bladder: Removed
Breast: Mastectomy (Right, Left, Both)
Breast: Lumpectomy (Right, Left, Both)
Breast: Biopsy
Colon:
-Colon Cancer Resection
-Diverticulitis
-Inflammatory Bowel Disease
Gallbladder:
-Removed
Heart:
-Biological Valve Replacement
Heart:
-Coronary Artery Bypass
-Mechanical Valve Replacement
-Transplant
-PTCA
Joint Replacement:
-Hip (Right, Left, Both)
-Knee (Right, Left, Both)
Kidney:
-Biopsy
-Removed (Right, Left)
-Stone Removal
-Transplant
Liver:
-Hepatectomy
-Transplant
-Shunt
Ovaries Removed:
-Endometriosis
-Cyst
-Ovarian Cancer
Ovaries:
-Tubal Ligation
Pancreas: Removed
Prostate Removed:
-Prostate Cancer
-Biopsy
-TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin:
-Basal Cell Carcinoma
-Squamous Cell Carcinoma
-Melanoma
Skin: Biopsy
Spleen: Removed
Testicles: Removed (Right, Left, Both)
Uterus
Hysterectomy:
-Fibroids
-Uterine Cancer
-Cervical Cancer
None

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

Other _____

Lala M. Stawowy MD
9150 Huebner Road, Suite 330
San Antonio, TX 78240

Are you pregnant? Yes No

Do you wear Sunscreen? Yes No If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

When you are exposed to sunlight do you: (Check most applicable)
___ Always burn
___Usually burn, rarely ran
___Often burn, tan slowly
___Sometimes burn, tan well
___Rarely burn, always tan
___Never burn, deeply tan

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications)
_____
_____

Allergies: (Please enter all allergies)
_____
_____

Pharmacy: Name:_____
Street:_____ Zipcode:_____
Telephone #:_____

Social History: (Please circle one)

Cigarette Smoking:
Never smoked
Quit: former smoker
Smoker: Less than daily
Smoker: Daily

Alcohol Use:
YES
NO

Language:
English
Spanish
Other:_____

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

What is your caffeine use?
Once a day
A few times a week
A few times a month
Never

Past history of?
IV drug abuse
Blood transfusions
Unprotected intercourse

Occupation and Workplace_____
Animals in home? _____ Hobbies: _____
Place of Residence_____