OCALA PLASTIC SURGERY & DERMATOLOGY

PATIENT MEDICAL HISTORY FORM

Name: _____ **Date of Birth:** _____

Primary Care Physician: _____ **Age:** _____ **Sex:** Male / Female

Preferred Pharmacy: _____ **Pharmacy phone #:** _____

LAB if required (ple**ase circle)** Ameripath/Dermpath LabCorp Quest Korpath

Current Reason You Are Here Today: _____

MEDICAL HISTORY: (Please circle all that apply)

Anemia	Eye Disease _____	HIV/AIDS
Anxiety/Depression	Excessive Scarring	Hypo/Hyper Thyroid
Arthritis/Rheumatoid or Psoriatic	Gerd	Kidney Problems
Artificial Joints	Heart Attack	Lymphoma
Asthma/COPD	Heart Disease	Pacemaker
Bleeding Disorder	Heart Failure	Radiation Treatments
Cancer/type _____	Heart Valve Replacement	Seizures
Coronary Artery Disease	Hepatitis	Stomach Problems
Chronic Lung Disease	High Blood Pressure	Stroke
Diabetes/type_____	High Cholesterol	NONE OF THE ABOVE

Other: _____

SKIN HISTORY: (Please circle all that apply)

Actinic Keratosis	Dry Skin	Keloid scars	Redness/Dark	Wrinkles
Acne	Eczema	Melanoma	SCC	
BCC (basal cell)	Flaking or itchy	Precancerous	Spots	
Bleeding/Bruising	scalp	Moles	Sunburn	NONE OF THE
Cold Sores	Itching	Psoriasis	(blistering)	ABOVE

If you've previously had skin cancer, please list body location(s)**:** _____

Other skin issues: _____

Do you wear sunscreen? Yes No Do you use indoor tanning? Yes No Never

Number of alcoholic drinks per day (circle) None Less than 1 per day 1-2 per day 3 or more per day

Do you smoke/vape? (circle) Former Never Current (packs/pods per day/week) _____

Any psychiatric problems, nervous breakdown or currently under the care of a psychiatrist? Yes No

Family Medical History of Melanoma? Yes No Who? _____

Family Medical History of Cancer? Yes No Who? _____ Type? _____

Family Medical History of Heart Issues? Yes No Who? _____ Condition? _____

PHYSICAL EXAM: Height_____ Weight _____lbs. Bra Size: _____

PAST SURGERIES & HOSPITALIZATIONS: (please list all surgeries - including cosmetic)

_____ _____

_____

_____ _____

_____ _____

_____ _____

MEDICATIONS (Please enter all current medications including vitamins and/or supplements including dosages)

MEDICATION	**DOSE** (mg, pill, etc) **&** **Times per day**

☐ I do not take any medicines, vitamins or supplements

Do you have any allergies/reactions to medication or anesthesia? Yes No Please explain: _____

_____

Bleeding Tendencies: _____

ALERTS:

Allergy to adhesive
Allergy to lidocaine
Allergy to Topical Antibiotics
Blood thinner
Bone Marrow Transplant
Defibrillator
Healing Problems
MRSA
Pacemaker
POTS
Pregnancy or planning for in future
Rapid Heart Rate w/Epinephrine
Require Antibiotics prior to surgery

Other: _____