John W. Tyrone, MD

108 NW 76th Drive Suite A, Gainesville, FL 32607

Tel:(352)332-1150 Fax:(352)332-1044

MEDICAL HISTORY

Date: _____

Name: _____ Nickname: _____

First Middle Last

Age: _____ Sex: Male/ Female Race:_____ Height:_____ Weight:_____

Reason for visit: _____

PAST MEDICAL HISTORY *List any medical conditions for which you have been treated:*

_____

_____

PAST SURGICAL HISTORY *List any operations, including cosmetic, you have had:*

_____

_____

_____

Do you have a history of: (Please check yes/no)

Yes No	Yes No	Yes No	Yes No
☐☐ *Asthma*	☐☐ *Hirsutism*	☐☐ *Hormone Therapy*	☐☐ *Keloid Scars*
☐☐ *Acne*	☐☐ *Diabetes*	☐☐ *Latex Allergy*	☐☐ *Fever Blisters*
☐☐ *Bleeding Disorders*	☐☐ *GERD/Reflux/Ulcers*	☐☐ *Liver Disease*	☐☐ *Immune Disorder*
☐☐ *Blood Clots*	☐☐ *Heart Disease*	☐☐ *Nervous Disorder*	☐☐ *Skin Diseases*
☐☐ *Breast Disease*	☐☐ *Lupus Erythematosus*	☐☐ *PCOS*	☐☐ *Permanent Makeup*
☐☐ *Burn/Skin Grafts*	☐☐ *Hepatitis*	☐☐ *Thyroid Disease*	☐☐ *Metal Implants*
☐☐ *Cancer*	☐☐ *High Blood Pressure*	☐☐ *Tuberculosis*	☐☐ *Chronic headaches*
☐☐ *Contact Dermatitis*	☐☐ *Hypoglycemia*	☐☐ *Seizures*	☐☐ *Lupus*
☐☐ *Depression*	☐☐ *Shingles*	☐☐ *Psoriasis*	☐☐ *Precocious Puberty*
☐☐ *Endocrine Disorder*	☐☐ *Kidney Disease*	☐☐ *Herpes*	☐☐ *Pacemaker*
☐☐ *Fibromyalgia*	☐☐ *Sinus*	☐☐ *Vitiligo*	☐☐ *Mitral Valve Prolapse*

Please list all ***MEDICATIONS*** *and* ***dosage*** *recently or regularly taken (include herbal and vitamins):*

_____

_____

Please list all ***ALLERGIES*** *to any* ***medications***:_____

_____

Please list any ***NON-MEDICATION*** ***ALLERGIES*** *(i.e. latex, seasonal, topical products):*_____

_____

WOMEN'S HEALTH

Have you ever been pregnant: _____How many times: _____ How many deliveries: _____

How many children do you have: _____ Did you breastfeed: ***Yes / No*** *When did you stop: _____*

Is there a possibility that you are currently pregnant or are you actively trying to get pregnant? Yes/ No

Date of most recent MAMMOGRAM: _____ Results: _____

Liposuction / tummy tuck patients*: Are you at your goal weight?* ***Yes / No*** *Interested in weight loss program?* ***Yes / No***

SOCIAL HISTORY

Have you ever regularly smoked cigarettes / tobacco? ***YES/ NO*** *If yes, how many packs per day?* _____

How many years did you smoke? _____ *When did you stop smoking?* _____

Alcohol Use: None / Occasionally / Daily *History of Drug use:*_____

Exercise: None / Occasionally / Daily *Diet Pills:*_____

Have you used Accutane in the last 6 months? ***Yes / No*** *If yes, how recently?*_____

Have you had a chemical peel or facial within the last six months? ***Yes / No***

Have you had any previous laser treatment or other skin treatments to the area being treated? ***Yes / No***

If yes, what have you had done and how long ago? _____

Are you currently using or have used a tanning bed or sunless tanners? ***Yes/ No*** *If yes, how long ago?*_____

Has the area being treated been exposed to the sun within the last four to six weeks? ***Yes/ No***

Are you or have you ever used (please circle): ***Azelex/ Differin/ Renova/ RetinA/ Tarazac/ Glycolic or AHA acids***

Please list the skin care products which you are currently using: _____

_____

Have you had any permanent cosmetic tattooing in the area to be treated? ***Yes/ No***

Have you or anyone in your family ever had unusual reactions to anesthesia

Including muscle weakness, jaundice, breathing problems, or unexpected fevers? ***Yes/ No***

Do you have metal implants in your body? ***Yes/ No***

*If yes, where?*_____

Do you have any of the following? (Please circle) ***Loose or chipped teeth/ caps/ dentures/ contact lenses/ piercings***

Have you ever seen a cardiologist? ***Yes/ No***

Physician name: _____ *Date of last EKG:* _____

Do you bruise easily or bleed excessively? ***Yes/ No***

Have you ever had a blood clot in your legs or lungs (DVT or pulmonary embolism)? ***Yes/ No***

Do you have thickening of scars or keloids following injury or surgery? ***Yes/ No***

Have you ever had any weakness of the face or drooping of any part of the face? ***Yes/ No***

Have you ever had "dry eyes" or eye infections? ***Yes/ No***

Have you ever had fainting spells, seizures, blackouts, TIA's, or strokes? ***Yes/ No***

Do you have any neck problems or arthritis? ***Yes/ No***

Do you have any problems with motion sickness or nausea after anesthesia? ***Yes/ No***

Have you ever received a blood transfusion? ***Yes/ No***

Do you have any infectious diseases? ***Yes/ No***

Have you ever seen a psychiatrist? ***Yes/ No***

Are you allergic to any antibiotic ointments or skin care products? ***Yes/ No***

If yes, please list the medication and reaction: _____

_____

FAMILY HISTORY *Please list any illnesses that run in your family:* _____

_____

Best contact number: _____ *May we leave a message?* ***Yes / No***

Patient's Signature: _____ *Date:* _____