Name: ______________________ DOB: __________ Date: ______________

Medical History Form

Primary Doctor/Clinic: ______________________ Referred by your doctor? Yes / No

Reason for today's visit: ______________________

Do you have any concerns that you would like addressed? Yes / No If yes, ______________________

ALLERGIES: ______________________

MEDICATIONS: ______________________

Skin Conditions and Social History	Yes	No
Have you had skin cancer	☐	☐
Melanoma	☐	☐
Basal Cell Carcinoma	☐	☐
Squamous Cell Carcinoma	☐	☐
Have you had abnormal / dysplastic moles	☐	☐
Have you had pre-cancerous Actinic Keratoses	☐	☐
List any other skin conditions you have: (Ex: Eczema, Psoriasis, Acne, Rosacea, Vitiligo) ____________		
Do you use sunscreen? SPF # ________	☐	☐
Do you use tanning booths?	☐	☐
Have you had blistering sunburns?	☐	☐
Do you heal with thick (keloid) scars?	☐	☐
Do you bleed / bruise easily?	☐	☐
Do you react to bandages or adhesive?	☐	☐
Do you need antibiotics for the dentist?	☐	☐
Have you had staph infections / MRSA?	☐	☐
Do you work outdoors?	☐	☐
Do you smoke? # cigarettes/day ________	☐	☐
Do you drink alcohol? # drinks / day ________	☐	☐
Do you take aspirin? Blood thinners?	☐	☐
Are you allergic to local anesthesia?	☐	☐

Past Surgeries	Yes	No
Pacemaker / Defibrillator	☐	☐
Joint Replacement Site: ____________	☐	☐
Heart Valve Replacement	☐	☐
Organ Transplant Type: ____________	☐	☐
Tubal Ligation	☐	☐
List Other Surgeries: ____________		

FAMILY Medical Problems	Yes	No
Skin Cancer	☐	☐
Melanoma	☐	☐
Basal Cell Carcinoma	☐	☐
Squamous Cell Carcinoma	☐	☐
Abnormal Moles	☐	☐
Eczema	☐	☐
Asthma	☐	☐
Seasonal Allergies	☐	☐
Psoriasis	☐	☐
Autoimmune Disease	☐	☐
(Lupus, Rheumatoid Arthritis, MS, Crohn's, Colitis, Thyroid) ____________		

ROS: Circle any Symptoms you currently have				
General	Fatigue	Weight Loss		
Immune	Fever	Night Sweats	Frequent Infections	
Eye	Dryness	Blurry Vision	Irritation	
Heart	Chest Pain	Ankle Swelling	Palpitations	
Lungs	Cough	Shortness of Breath		
GI	Nausea	Vomiting	Diarrhea	
Joint	Stiffness	Pain	Cramping	
Neuro	Numbness	Tingling	Headache	Weakness
Endocrine	Heat/Cold Intolerance	Excessive Thirst		
Psych	Depression	Anxiety		
Heme	Easy Bleeding	Bruising	Swollen Nodes	
Skin	Itch	Burning	Redness	Discoloration	Scale
Females				
Pregnant	Nursing	Irregular Periods		
Planning Pregnancy Soon	Birth Control Pills			

PMH: Circle your Medical Problems				
Cancer	Breast	Prostate	Colon	
Immune	HIV	Immune Deficiency		
Eyes	Glaucoma	Cataract	Rosacea	
Nose	Seasonal Allergies	Chronic Rhinitis		
Heart	High Blood Pressure	Heart Attack		
	High Cholesterol	Atrial Fibrillation		
	Heart Valve Problems	Clotting Disorder		
Lungs	COPD	Asthma	Tuberculosis	
GI	Acid Reflux	Colitis	Irritable Bowel	
	Hepatitis B	Hepatitis C		
Joint	Arthritis	Joint Replacement		
Brain	Stroke	Seizures	Migraines	Headaches
Endocrine	Thyroid	Diabetes	Polycystic Ovary	
Psych	Depression	Anxiety	Attention Deficit	
Other				

______________________ ______________________

Patient's Signature Date

______________________ ______________________

Provider's Signature Date

OFMC Dermatology and Aesthetic Center
2121 SW 22nd Place
Ocala, FL 34471
(352) 368-1350

Dear Patient:

Welcome to Ocala Family Medical Center. Our goal is to improve your quality of life.

It is our policy to charge for missed appointments at the rate of:

New Patient Appointment: $100.00 dollars

Follow Up Appointment: $75.00 dollars

Missed Procedures: $100.00 dollars

Please help us to serve you better by keeping your scheduled appointments. If you are unable to keep this appointment, please call (352) 368-1350 to reschedule your appointment at least 24-hours in advance.

Sincerely,
The Staff of Ocala Family Medical Center

I have read and understand the above no show policy for OFMC Dermatology and Aesthetic Center.

______________________________ ____________________
Print Name Witness

______________________________ ____________________
Signature Date