John W. Tyrone, MD

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

352-332-1150 Fax: 352-332-1044

MEDICAL HISTORY **DATE:_____**

Name: _____ Nickname:_____
First Middle Last

Age:_____ Sex: Male/Femal 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 NOW or have you EVER had: (please check yes or no)

yes	no		yes	no		yes	no		yes	no	
☐	☐	chronic headaches	☐	☐	sleep apnea	☐	☐	thyroid disease	☐	☐	bleeding disorder
☐	☐	seizures	☐	☐	heart disease	☐	☐	liver disease	☐	☐	blood clot
☐	☐	stroke	☐	☐	heart attack	☐	☐	hepatitis	☐	☐	fibromyalgia
☐	☐	numbness/tingling	☐	☐	heart murmur	☐	☐	kidney disease	☐	☐	arthritis
☐	☐	sinus problems	☐	☐	mitral valve prolapse	☐	☐	IBS/gastroenteritis	☐	☐	TMJ/lockjaw
☐	☐	anxiety	☐	☐	pacemaker	☐	☐	diabetes	☐	☐	dermatitis
☐	☐	depression	☐	☐	irregular heartbeats	☐	☐	hypoglycemia	☐	☐	skin diseases
☐	☐	asthma	☐	☐	high blood pressure	☐	☐	GERD/reflux/ulcers	☐	☐	metal implants
☐	☐	lung disease/COPD	☐	☐	high cholesterol	☐	☐	cancer	☐	☐	latex sensitivity
☐	☐	tuberculosis	☐	☐	breast disease	☐	☐	immune disorder	☐	☐	herpes/cold sores

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

_____

_____

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

_____

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

_____

WOMEN'S HEALTH

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

How many children do you have: _____ Did you breastfeed:_____ When did you stop: _____

Date of most recent MAMMOGRAM:_____ Results:_____

Breast augmentation/reduction patients: Current bra size: _____ Desired bra size: _____

Date of prior Augmentation: _____ **Circle one**: SALINE or SILICONE / UNDER or OVER the muscle?

Where is incision? _____ How many cc's? _____ History of capsular contracture? Y/N

Liposuction / tummy tuck patients: Are you at your goal weight?_____ Interested in weight loss program?_____

SOCIAL HISTORY (Please answer all questions even if it is Not Applicable to you)

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:_____

Occupation/normal activity level:_____

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

What products do you use on your skin? Soap___ Scrubs____ Toner____ Creams_____ Sunscreen____
Are you or have you ever used: (Please circle)

Azelex Differin Renova RetinA Tarazac

Accutane Frequent Blemishes Glycolic or AHA acids

Is there a possibility that you may be pregnant at this time? Yes No
Are you actively trying to get pregnant? Yes No
Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems, or unexpected fevers? Yes No
Do you have: loose or chipped teeth caps dentures contact lenses metal body piercings None Do you have metal implants in your body? Yes No

If yes, where: _____
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
Please list the skin care products which you are now using:
_____
Are you allergic to any antibiotic ointments? Yes No

Please list:
_____

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

Patient's Signature: _____ Date:_____