Anke Ott-Young MD
Patient Medical History

Account #: «Person_ID»

Name: _____ Date: _____

Reason for todays visit: _____

Who is your primary care physician? _____

Are you currently under the care of or have ever been treated by a medical physician for any significant illness other than colds, flu or virus? _____

Returning Patients: have you had any changes to your medical condition since your last visit? Please include any changes to medication. If so please explain: ❑ No

Height: _____ Weight: _____

Patient Occupation: _____

Do you have any of the following conditions? If YES , please explain:

Arthritis	❑ No	❑ Yes	
Asthma, emphysema	❑ No	❑ Yes	
Bleeding problems, bruise easily	❑ No	❑ Yes	
Breast cancer	❑ No	❑ Yes	
Cancer	❑ No	❑ Yes	
Chest pain, angina	❑ No	❑ Yes	
Cold symptoms, frequent cough	❑ No	❑ Yes	
Convulsions, epilepsy	❑ No	❑ Yes	
Depression, anxiety	❑ No	❑ Yes	
Diabetes	❑ No	❑ Yes	
Heart disease	❑ No	❑ Yes	
Hepatitis	❑ No	❑ Yes	
Hiatal hernia, gastroesophageal reflux	❑ No	❑ Yes	
Hypercholesterolemia	❑ No	❑ Yes	
Hypertension	❑ No	❑ Yes	
Hyperthyroidism	❑ No	❑ Yes	
Kidney disease, prostate disease	❑ No	❑ Yes	
Liver disease, jaundice	❑ No	❑ Yes	
Skin cancer	❑ No	❑ Yes	
Skin disease	❑ No	❑ Yes	
Sleep apnea	❑ No	❑ Yes	
Stroke, paralysis, arm/leg weakness	❑ No	❑ Yes	
Thyroid disease	❑ No	❑ Yes	
Other	❑ No	❑ Yes	

Patient Past Surgeries/Hospitalizations ❑ None

	Surgery	Date	Anesthesia complications	Notes
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

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Patient Family History:

❑ None	**Yes**	**Afflicted family member**
Abnormal bleeding or clotting	❑	
Anesthesia problems	❑	
Autoimmune disorders	❑	
Brain tumor	❑	
Breast cancer	❑	
Cleft lip	❑	
Cleft palate	❑	
Diabetes	❑	
Drug allergies	❑	
Endocrine disease	❑	
Heart disease	❑	
Hemophilia	❑	
High blood pressure	❑	
Skin cancer	❑	
Skin disease	❑	
Other	❑	

Allergies: ❑ None ❑ Yes Please list: _____

Are you presently taking oral contraceptives? ❑ No ❑ Yes

Current Medications:

Are you presently taking any medications? ❑ No ❑ Yes

If yes please specify below: Please include over the counter meds and herbal remedies

	Name of Medication	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Pharmacy Information:

Name: _____

Address: _____ Telephone: ( )

Alcohol use: ❑ None ❑ Occasional How many drinks per week _____

Smoking Status: ❑ Current every day smoker ❑ Former smoker ❑ Never smoker ❑ Smoker, current status unknown ❑ Unknown if ever smoked ❑ Heavy tobacco smoker ❑ Light tobacco smoker

Do you use smokeless cigarettes? ❑ No ❑ Yes

Does your skin appear fragile, burns easily? ❑ No ❑ Yes

Do you form thick or raised scarring from a cut or burn? ❑ No ❑ Yes

Do you ever get cold sores? ❑ No ❑ Yes

Females:

Do you get regular periods? ❑ No ❑ Yes

Are you pregnant or lactating? ❑ No ❑ Yes

Bra size: _____

Most recent mammogram date/facility? _____