Please fill out this form using Adobe Reader (free software available here). For safari users save the form to your download folder and reopen with Adobe Reader 10.1.1 or later OR open with Firefox (download available here).
When you are finished, you can print out the form and fax it to us at 352-242-0648 or bring it to your appointment.
You can also email the form directly to us by using the "email" button located at the bottom of the last page.

PATIENT INFORMATION

PATIENT'S FULL NAME: _____ Date: _____

EMAIL: _____

ADDRESS _____

CITY/STATE/ZIP _____

HM PH# (____) _____ WK PH# (____) _____ CELL # (____) _____

PATIENT'S AGE _____ BIRTH DATE _____/ _____ / _____

SEX: ☐ MALE ☐ FEMALE REFERRED BY _____

HOW DID YOU HEAR ABOUT US? _____

REASON FOR TODAY'S VISIT _____

EMERGENCY CONTACT _____

PH # (____)_____ RELATIONSHIP TO PATIENT _____

RESPONSIBLE PARTY (if different from patient)

NAME OF SPOUSE OR PARENT IF PATIENT IS A MINOR _____

ADDRESS _____

HM PH# (____) _____ WK PH#(____) _____ RELATIONSHIP TO PATIENT _____

Signature _____ Date: _____

WITNESS _____

MEDICAL HISTORY FORM

PATIENT NAME: _____

HEIGHT _____ WEIGHT _____

My last physical exam was on _____

Name and phone # of physician _____

MEDICAL HISTORY (Please check the appropriate box if you have or have had any of the following)

CARDIAC: ☐ No significant history

☐ High Blood Pressure ☐ Chest Pain ☐ Shortness of Breath ☐ Dizziness ☐ Fainting

☐ Pacemaker ☐ Murmur ☐ Abnormal heart rhythm ☐ Valve Disorder ☐ Ankle swelling

☐ Increased Cholesterol ☐ Heart Attack ☐ Arteriosclerosis ☐ Low Blood Pressure

Other: _____

PULMONARY: ☐ No significant history

☐ Coughing up blood ☐ Asthma ☐ Shortness of Breath ☐ Wheezing

☐ Recent Upper Respiratory Infection ☐ Sleep Apnea ☐ Pneumonia

☐ Bronchitis ☐ Sinus Problems/Hay Fever ☐ Tuberculosis ☐ COPD/Emphysema

Other: _____

NEUROLOGICAL - NEUROMUSCULAR: ☐ No significant history

☐ Cramps ☐ Numbness ☐ Tingling ☐ Spasms ☐ Stiffness ☐ Weakness

☐ Arthritis ☐ Rheumatoid Arthritis ☐ TMJ ☐ Seizures ☐ Epilepsy ☐ Stroke/TIA

Other: _____

GI: ☐ No significant history

☐ Diarrhea ☐ Ulcer ☐ Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Blood in Stool

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Irritable Bowel Syndrome

Other: _____

GU: ☐ No significant history

☐ Frequency ☐ Urgency ☐ Incontinence ☐ Discharge ☐ Discomfort ☐ Stones

☐ Blood in Urine ☐ Recent UTI ☐ Abnormal Vaginal Bleeding

Other:

SKIN: ☐ No significant history

☐ Rashes ☐ Lesions ☐ Bruising ☐ Delayed Wound Healing ☐ Psoriasis

☐ Mole Changes ☐ Frequent or recurring mouth sores ☐ Skin Cancer

Other:

ENDOCRINE: ☐ No significant history

☐ Diabetes Type: Usual Blood Glucose Range

☐ Hyperthyroid ☐ Hypothyroid

Other:

HEMATOLOGY/IMMUNE: ☐ No significant history

☐ Steroid Use ☐ Anemia ☐ Sickle Cell ☐ Bleeding Disorder ☐ Hepatitis

☐ Autoimmune Disorder ☐ Gout ☐ Organ Transplant ☐ Hereditary Angioedema

☐ Radiation ☐ Chemotherapy ☐ Cancer Type:

Other:

MENTAL HEALTH: ☐ No significant history

☐ Depression ☐ Anxiety Disorder ☐ Post-Traumatic Stress ☐ Eating Disorder

Other

PAST SURGICAL HISTORY

(Please list previous operations and dates)

ANY PROBLEMS WITH SURGERY OR ANESTHESIA ☐ YES ☐ NO

If yes, please explain

HAVE YOU EVER HAD A BLOOD TRANSFUSION ☐ YES ☐ NO

MEDICATIONS

Please list any medications you are currently taking with the dose and frequency. Please include any over the counter medications, aspirin, birth control pills and/or herbal remedies.

Have you taken any of these medications for osteoporosis, Paget's disease, or cancer?

☐ Zoledronic (Reclast) ☐ Etidronate (Didronel) ☐ Tiludronate (Skelid)

☐ Alendronate (Fosamax) ☐ Risedronate (Actonel) ☐ Ibandronate (Boniva)

☐ Pamidronate (Aredia) ☐ Zoledronate (Zometa)

DRUG ALLERGIES ☐ No known drug allergies

(Please list reaction you experience due to your allergy)

Have you ever had a reaction to Latex, Betadine, Surgical Tape or Eggs? ☐ YES ☐ NO

(If yes, please check which one) ☐ Latex ☐ Betadine ☐ Surgical Tape ☐ Eggs

SOCIAL HISTORY

Do you smoke? ☐ YES ☐ NO If yes, packs per day

Do you drink alcohol? ☐ YES ☐ NO

If yes, frequency: ☐ Occaisionally ☐ Frequently ☐ Regularly

Do you take recreational drugs, such as marijuana and/or cocaine? ☐ YES ☐ NO

GENERAL QUESTIONS

Have you taken aspirin-containing drugs in the past two weeks? ☐ YES ☐ NO

Have you had any trouble associated with previous treatment? ☐ YES ☐ NO

Are you wearing contact lenses? ☐ YES ☐ NO

Are you wearing a removable dental appliance today? ☐ YES ☐ NO

Women:

Are you pregnant or trying to become pregnant? ☐ YES ☐ NO

Are you nursing? ☐ YES ☐ NO

Date of your last menstrual period: _____

CHIEF COMPLAINT (why are you here?)

_____

Do you consent to having an x-ray taken today if needed? ☐ YES ☐ NO

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Johnson, or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature _____ Date: _____

Printed Name: _____

If someone other than the patient filled out this form for the patient, please sign and date below.
I certify that I helped the patient fill this form out and that I am 18 years of age or older. I certify that I helped the patient fill out this form for the following reason(s):

_____

Signature _____ Date: _____

Printed Name: _____

Relationship to patient: _____

ADVANCED FACES, LLC/DR. CHRISTOPHER JOHNSON

Please initial to confirm whom we may discuss your medical and financial information with:

☐ My Husband: _____

☐ medical ☐ financial

☐ My Wife: _____

☐ medical ☐ financial

☐ My Mother: _____

☐ medical ☐ financial

☐ My Father: _____

☐ medical ☐ financial

☐ My Mother-in-Law: _____

☐ medical ☐ financial

☐ My Father-in-Law: _____

☐ medical ☐ financial

☐ My Children: _____

☐ medical ☐ financial

☐ Other (Friends or Partners)

Please list specific names: _____

☐ medical ☐ financial

When calling to discuss your upcoming appointment or financial information may we:

☐ Leave a detailed message on your home phone

☐ Leave a detailed message on your cell phone

☐ Leave a detailed message on your work phone

☐ DO NOT leave any information but person calling and contact number

Signature: _____

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