Farrell Plastic Surgery
John A. Jarrell IV, M.D., FACS

MEDICAL HISTORY FORM

Office Use Only MR#_____
Acct.#_____
T_____ P_____ BP_____R_____
Height_____Weight_____ Date_____
BMI _____ BSA _____
Patient Name _____ _____
Last First Middle Date of Birth Age
Referred By _____ Primary Care Doctor _____
Reason for appointment _____
If applicable: date of injury or onset of problem _____
Is this the result of a work or car accident? ☐Yes ☐No _____
What makes the problem/pain worse or better? _____

Past Medical History

Have you ever been a patient in this office? ☐Yes ☐No _____

IF ADDITIONAL SPACE IS NEEDED IN ANY SECTION OF THIS FORM ATTACH A SEPARATE SHEET

List any current medical problems you have.

Medical Problem	Medical Problem

Surgical/Hospitalization History

Have you ever had any problems with anesthesia? ☐Yes ☐No If yes, explain_____
Have you Had Cosmetic Surgery in the past? ☐Yes ☐No Procedure_____

Type of Surgery or Hospitalization	Date	Type of Surgery or Hospitalization	Date

Present Medications: Prescriptions or non-prescriptions

Name of Medication	Dosage/Frequency	Name of Medication	Dosage/Frequency

Preferred Pharmacy Information:_____
Regular Aspirin Use? ☐Yes ☐No Dosage & Frequency_____
Regular NSA use? (Advil, Motrin, and Ibuprofen) ☐Yes ☐No Dosage & Frequency_____
Non-Prescription (Vitamins; Herbs) _____

Allergies: List medications and/or foods that you are allergic to and what kind of reaction you have.

Medication/Food	Reaction	Medication/Food	Reaction

Latex Allergy: ☐Yes ☐No **Tape Allergy:** ☐ Yes ☐No

Social History

Student:☐ Yes ☐No Grade Level_____ ☐Full time ☐Part time _____
Occupation _____ Employer _____ How long? _____
Marital Status ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed _____

***For Women:** **MR#**_____

Number of Pregnancies: _____ Number of Children: _____ Current Bra Size:_____

Breast Fed? ☐Yes ☐No How Long/When stopped? _____

Date of Last Mammogram: ____/____/____ Results/where performed? _____

Use of Alcohol ☐Never ☐Rarely ☐Moderate (2 drinks/day) ☐Heavy (more than 2 drinks/day)_____

Tobacco Use:☐Smoker_____Packs/day Previous Smoker ☐Yes ☐No Date Quit___/___/___ ☐Vape__ _☐Never_____

Drug Use ☐Never ☐Yes Type: _____

Have you ever been under psychiatric care? ☐Yes ☐No When?_____ Why?_____

Family History: Any Family history of medical problems: If so, please list.

Type of Problem	Family Member	Type of Problem	Family Member

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD A PROBLEM WITH?

Ear/Nose/Mouth/Throat
- ☐Allergic Rhinitis
- ☐Chronic Sinusitis
- ☐Ear Drainage
- ☐Ear Infections
- ☐Hearing Loss
- ☐Mouth Sores
- ☐Nasal Polyps
- ☐Nose Bleeds
- ☐Ringing in Ears

Cardiovascular
- ☐Chest Pain
- ☐Difficulty Lying Flat
- ☐Dizziness
- ☐Fainting Spells
- ☐Murmur
- ☐Palpitations
- ☐Shortness of Breath
- ☐Swelling Ankles
- ☐Varicose Veins

Musculoskeletal
- ☐Weakness of muscles/joints
- ☐Joint Stiffness/swelling
- ☐Neck/Back Pain
- ☐Cold Extremities
- ☐Fibromyalgia
- ☐Joint Pain
- ☐Back Injury
- ☐Muscle Pain/Cramps
- ☐Arthritis

Allergic
- ☐Allergies/Hay Fever
- ☐Anaphylaxis
- ☐Hives

Gastrointestinal
- ☐Abdominal Pain
- ☐Constipation
- ☐Heartburn/Reflux
- ☐Hepatitis
- ☐Jaundice
- ☐Liver Disease
- ☐Nausea/Vomiting
- ☐Stomach Ulcers

Endocrine
- ☐Excessive thirst
- ☐Excessive urination
- ☐Heat/Cold intolerance
- ☐Loss of Hair
- ☐Swelling Glands

Eyes
- ☐Blurred/Double Vision
- ☐Cataracts
- ☐Dry Eyes
- ☐Eye disease
- ☐Eye Injury
- ☐Glaucoma
- ☐Glasses/Contacts

Psychiatric
- ☐ADD/ADHD
- ☐Alcohol Abuse
- ☐Anxiety
- ☐Bipolar Disease
- ☐Confusion
- ☐Depression
- ☐Drug Dependency
- ☐Insomnia
- ☐Memory Loss
- ☐Mood Swings
- ☐Nervousness

Hematology
- ☐Abnormal Bleeding in your Family
- ☐Anemia
- ☐Easy Bleeding/Bruising
- ☐Clotting Disorder
- ☐Deep Venous Blood Clots (DVT)
- ☐Gums Bleed Easily
- ☐Known HIV/AIDS exposure
- ☐Slow to Heal after Cuts
- ☐Transfusion history

Respiratory
- ☐Asthma/Wheezing
- ☐Chronic/Frequent cough
- ☐COPD/Emphysema
- ☐Coughing Blood
- ☐Sleep Apnea
- ☐Tuberculosis

Neurologic
- ☐Head Injury
- ☐Migraines/Headache
- ☐Numbness/Tingling
- ☐Seizure Disorder
- ☐Stroke/TIA
- ☐Tremors

Integument/Breast
- ☐Breast Discharge
- ☐Breast Pain
- ☐Breast Cancer
- ☐Changing Skin
- ☐Eczema
- ☐Fibrocystic Disease
- ☐Skin Lesions
- ☐Lump in Breast
- ☐Rash/Itching
- ☐Skin Cancer

Constitutional
- ☐Fever
- ☐Fatigue
- ☐Weight Loss
- ☐Weight Gain

Genitourinary
- ☐Abnormal Discharge
- ☐Blood in Urine
- ☐Incontinence
- ☐Urinary Burning/Frequency

☐ **I have none of the above symptoms.**

PRESCRIPTION REFILL POLICY

Refills for Prescription Medications need to be called in to our office between 8:00 am - 4:00 pm Monday through Thursday and Friday 8:00 am – 3:00 pm. All approved prescriptions will be called into the pharmacy by the end of that business day. Prescriptions should be taken "AS DIRECTED". Early refills may be denied. No medications will be refilled after hours or on weekends.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature Date

I have reviewed the above information with the patient.

Physician Signature Date