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

Ocala Family Medical Center
2230 SW 19th Avenue Road
Ocala, FL 34471
(352) 237-4133

Dear Patient:

Welcome to Ocala Family Medical Center, Inc. Our goal is to improve your quality of life. It is our policy to charge for missed appointments at the rate of:

Primary Care:

New Patient Appointment: $50.00

Follow Up Appointment: $50.00

Physical Therapy

Initial Evaluation: $100.00

Follow Up Appointment: $75.00

Specialist

New Patient Appointment: $100.00

Follow Up Appointment: $75.00

Missed Procedures: $100.00

Radiology

CT Appointment: $100.00

MRI Appointment: $100.00

Nuclear Appointment: $100.00

Ultrasound Appointment: $100.00

Please help us to serve you better by keeping your scheduled appointments. If you are unable to keep an appointment, please call (352) 237-4133 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.

Print Name	Date of Birth
Signature	Date

Effective: 02/02/2024