Great Bay
PLASTIC SURGERY
Jerome Sepic, M.D., PLLC

Patient Identification Area

MR#: Visit #:

Name:

DOB:

Patient Medical Data Sheet

Name:____ Occupation:______________________

Date of Birth:____________ Age:__________ Height:__________ Weight:__________ Are you pregnant? ☐ No ☐ Yes

Reason(s) for today's visit ____

Primary Care Physician:______________________________ **Referring Physician:**_______________________________

Medical History:____

Surgical History:____

Past problems with bleeding or anesthesia:____

Current medications with dosages:____

____

Allergies to Medications:____

Latex Allergies? ☐ No ☐ Yes Tested? ☐ No ☐ Yes

Family Medical History:____

Do you smoke? ☐ No ☐ Yes How much? _________ Do you drink alcohol? ☐ No ☐ Yes How much? __________

Do you currently use any unprescribed drugs /social drugs? ☐ No ☐ Yes

Do you have a healthcare proxy? ☐ No ☐ Yes

Review of Systems: *Do you have any problems with?* **(Please check yes or no for each condition below).**

Anxiety/Depression	☐ N	☐ Y	Heart	☐ N	☐ Y	Skin Ulcers	☐ N	☐ Y
Asthma	☐ N	☐ Y	Hepatitis	☐ N	☐ Y	Stomach/ Abdominal	☐ N	☐ Y
Back or Joints	☐ N	☐ Y	High Blood Pressure	☐ N	☐ Y	Stroke	☐ N	☐ Y
Bleeding/Clotting	☐ N	☐ Y	HIV/Immunodeficiency	☐ N	☐ Y	Thyroid	☐ N	☐ Y
Breathing	☐ N	☐ Y	Kidney Disorders	☐ N	☐ Y	Weight Changes	☐ N	☐ Y
Cancer/Tumor	☐ N	☐ Y	Liver Disease	☐ N	☐ Y	Other ____________________________		
Diabetes	☐ N	☐ Y	Seizures	☐ N	☐ Y	**Additional Information:**____________		
Hearing Impairment	☐ N	☐ Y	Sinus Problems	☐ N	☐ Y	_________________________________		

Date__________ Time________ Patient Signature _______________________________________

Date__________ Time________ Physician Signature ____MD