GREGORY J. MACKAY, MD, PC
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MEDICAL HISTORY

Today's Date___________________________

Last Name__________________________First Name___________________________Middle___________

Age________________ Date of Birth_____________________Height____________Weight____________

Weight changes in the last year: ____

What is the reason for today's visit?____

PAST MEDICAL HISTORY: Have you had or are you experiencing any of the following?

Tuberculosis	No	Yes	Blood Pressure	No	Yes	Anemia	No	Yes
Stroke	No	Yes	Heart Disease	No	Yes	Thyroid	No	Yes
Cancer	No	Yes	Hepatitis	No	Yes	Asthma	No	Yes
Lungs	No	Yes	Bleeding Problems	No	Yes	Arthritis	No	Yes
Diabetes	No	Yes	Clotting Problems	No	Yes	Sleep Apnea	No	Yes
Depression	No	Yes	DVT/PE	No	Yes	↑ Cholesterol	No	Yes

Other Medical Problems____

List Dates of Diagnosis____

Physician that Treated this Diagnosis____

Have you been tested for HIV? No Yes Test Results: Positive Negative Year tested_________

SURGICAL HISTORY: please list all operations and year performed:

Operation____ Year_______________________________

Operation____ Year_______________________________

Operation____ Year_______________________________

Indicate the **type(s) of anesthesia** received in the past, list any complications or reactions you experienced:

Local Anesthesia____

General Anesthesia____

Spinal/Epidural____

FAMILY HISTORY: Please indicate if your blood relatives have had any of the following and state which blood relative had the disease:

Arthritis	No	Yes	_________	DVT/PE	No	Yes	__________
Bowel Disease	No	Yes	_________	Mental Illness	No	Yes	__________
Breast Cancer	No	Yes	_________	Diabetes	No	Yes	__________
Cancer (other)	No	Yes	_________	Heart disease	No	Yes	__________
Chronic Lung Disease	No	Yes	_________	Liver disease	No	Yes	__________
High Blood Pressure	No	Yes	_________	High Cholesterol	No	Yes	__________
Stroke	No	Yes	_________	Thyroid Disease	No	Yes	__________

OTHER:____

SOCIAL HISTORY: Please answer the following:

Marital Status (circle one): Single Married Divorced Widowed

# of children and their ages: ____

Occupation: ____

Have you EVER smoked cigarettes? No Yes Packs/Day___________How many years?_______

Have you STOPPED smoking? No Yes Date____

Do you drink over 3 cups of caffeine per day? No Yes How much?___________________

Do you exercise? No Yes How many times per week? ___________________________

Do you regularly drink alcohol? No Yes How much?___________________

Do you wear glasses or contact lenses? No Yes

If you require surgery, who will be your caregiver?____

PLEASE CIRCLE MEDICATIONS YOU ARE TAKING:

Aspirin/Anacin	No	Yes	Insulin	No	Yes
Bufferin	No	Yes	Antibiotics	No	Yes
Motrin	No	Yes	Birth Control	No	Yes
Ibuprofen	No	Yes	Weight Reduction	No	Yes
Arthritis Meds	No	Yes	Blood Thinners	No	Yes
Oral Diabetes Meds	No	Yes	-Ex: Coumadin, Plavix, Heparin, Levenox		

Other Meds/Vitamins/Supplements and Doctor who prescribed each:

____

____

DRUGS/SUBSTANCES TO WHICH YOU ARE ALLERGIC:_________________________________

Are you allergic to: Latex: No Yes Surgical Tape: No Yes

OFFICE USE ONLY

BREAST PATIENTS

Sternal notch to nipple: Left ______ cm Right ______ cm Bra Size:______________

Nipple to breast: Left ______ cm Right ______ cm Desired Size:__________

Photos taken? Yes No BMI:_________________

LESION PATIENTS

Any nevus Yes No

Date first noticed_________________________ Date first noted changes___________________________

Photos taken? Yes No

Measurements: Length___________________ Width______________________

Site Documented____