Florida Medical Clinic
Your Life, Our Specialty

Henry Redmon, M.D.
Plastic Surgery

707 W. Fletcher Ave. • Tampa, FL 33612
Phone: 813.264.2676

Patient Name: _____________________________ Age:____ Sex:____ Height_____ Weight:______

Reason for Visit: ____

If injury, Date of Injury: ___________________________ Date of last Tetanus: __________________

Current or recent prescriptions or over the counter medication or ointments with dosage:

MEDICATION	DOSE	HOW OFTEN DO YOU TAKE IT (How many times a day)

If more room is needed please list additional medications on back.

Allergies	Reaction(s)

Latex Allergy? Yes ____ No______ Have you been diagnosed with sleep apnea? Yes _______ No _______

Hospitalizations/Surgeries (List dates)____

____

Have you had complication with anesthesia? Yes _____ No _____ Explain: ___________________________________

____

Are you currently being treated by another physician? Yes _____ No ______

What are you being treated for? ____

Do you Smoke? Yes _____ No ______ Do you use Tobacco? Yes _____ No _____ How many packs a day? ______

Do you use Alcohol? Yes _____ No ______ How many per week? ______________________________________

If Female: Is there any possibility you could be pregnant? Yes _____ No _______

Personal Medical HX: **Check all that apply.**

Asthma	______	
Cancer	______	**Type: __________________________________**
Depression	______	
Diabetes	______	**Type I or II (Circle one)**
Ischemic Heart Disease	______	
Hypertension	______	
Stroke	______	
______________	______	

Family HX: Check all that apply.

	Mother	Father	Brother	Sister	Other
Arthritis	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Ischemic Heart Disease	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____
Hyperlipidemia	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
_______________	_____	_____	_____	_____	_____

I authorize Dr. Redmon or his staff to take medical photographs throughout the course of my treatment, to be part of my medical records.

Signature: _____________________________________ **Date**: ______________