BAY DERMATOLOGY AND COSMETIC SURGERY, P.A.
Jason Swerdloff, M.D.
Board Certified, Facial Plastic Surgery/ENT
727-781-7080

Name: _____ DOB: _____ Age: _____

Marital Status: _____ Number of children and their ages and gender: _____

Occupation and place of employment: _____ Today's Date: _____/_____/_____

Person who referred you to our office: _____ Primary Care Physician: _____

Reason for this visit: _____

Please list your medications and Dosages (include supplements)

_____
_____
_____

Please list your drug allergies:

_____
_____
_____

Social History: Have you ever smoked cigarettes or cigars?
(If yes, how much do you currently smoke?) _____
(If applicable, provide quite date) _____
(How much alcohol do you drink? _____

Are you concerned about your appearance in any way? (Please be specific)
_____
Does this concern preoccupy you? _____
Do you think about it a lot and wish you could worry about it less? _____

Family History: Check all that apply to your parents, grandparents, or siblings:

_____ High Blood Pressure _____ Heart Disease _____Other (Please specify)
_____ Diabetes _____Cancer (include type)

Personal past Medical History:

_____Heart Disease _____ Lung Disease (asthma) _____Anxiety
_____ High Blood Pressure _____ Liver Problems _____Cancer (type)
_____ Diabetes _____ Kidney Problems _____ Depression
_____ Stroke _____ Thyroid Disease _____ Other (explain)

Please list your past surgeries: _____

Review of symptoms: Check if you experienced any of the following in the past 6 months. Please provide details if applicable:

_____ Chest Pain _____ Hoarseness _____Post Nasal Drip _____Hearing Loss

_____ Depression _____Short of breath _____Severe Headaches _____ Urinary Difficulty

_____ Diabetes _____ Kidney Problems _____ Depression _____ Bone/Muscle Pain

_____ Difficulty Swallowing _____ Discolored Nasal Drainage