KIMBERLY MARBLE, MD
PLASTIC AND RECONSTRUCTIVE SURGERY

CORE PHYSICIANS
an exeter health resource | The Art of Wellness

# PATIENT INFORMATION/MEDICAL HISTORY

| | | | |
|---|---|---|---|
| Today's date: | | | |
| Name: | Email Address: | Date of Birth: | Phone/Cell Number: |
| Address: | City: | State: | Zip Code: |
| Reason for visit: (*Please be specific) | | | |
| Primary Care Physician: | | Date of Last Mammogram: | |
| Pharmacy: | Pharmacy Town: | Pharmacy Phone: | |
| Age: | Height: | Weight: | |
| ☐ Male ☐ Female ☐ Transgender ☐ Transsexual | | | |
| Are you currently taking any medications or herbal remedies? ☐Yes ☐No<br>If yes, please indicate below. (*if more room is required please use back of form) | | | |

| Medication Name | Dosage | How often taken |
|---|---|---|
| | | |
| | | |
| | | |

| | | |
|---|---|---|
| Do you have a pain management contract or currently taking pain medication? ☐Yes ☐No If yes, please explain: | | |
| Do you have any chronic medical/mental conditions/illnesses? ☐Yes ☐No If yes, please explain: | | |
| Do you have any ALLERGIES to MEDICATIONS and/or LATEX? ☐Yes ☐No<br>If yes, please list allergies and adverse reactions: | | |
| Have you ever been hospitalized for a medical problem that did not require surgery? ☐Yes ☐No<br>If yes, please explain: | | |
| Have you had any prior operations and/or surgical procedures? If yes, please list: | | |
| Have you had any exposure to Hepatitis, MRSA or HIV? ☐Yes ☐No If Yes, please explain: | | |
| Do you have a history of high fever with/during anesthesia? ☐Yes ☐No If Yes, please explain: | | |
| Do you smoke? | If yes, how much? | If no, have you ever? |
| Do you drink alcohol? | If yes, how much? | |
| Do you drink: ☐Coffee ☐ Tea ☐Caffeinated Drinks | | |
| What is your occupation? | | |
| Please list below your family's medical history: | | |
| Mother: | Father: | |
| Brother: | Sister: | |
| How would you consider your overall health? | | |