Freeman
PLASTIC SURGERY
IDAHO FALLS & JACKSON HOLE

Dr. Mark E. Freeman
Health History & Physical

Name_____**Date**_____

Reason for appointment:_____

SS# or Driver's License # _____ **Referral Source:** _____

Height: _____ **Weight:** _____ **Date of Birth:** _____ **Age:** _____

Current occupation: _____ **Marriage Status:**_____

City of Residence:_____ **# of Full Term Births:** _____**Age of Youngest Living Child:** _____

Do you have any upcoming important events?_____

Personal History of Any of the Following Health Problems?

Yes	No		Yes	No		Yes	No	
□	□	Asthma	□	□	Rheumatoid Arthritis	□	□	Thyroid Disease
□	□	Kidney Disease	□	□	Tumor, Cancer	□	□	Glaucoma/Porphyria
□	□	Psychiatric Disorder	□	□	Seizures, Convulsions	□	□	Anesthesia problems
□	□	Hiatal Hernia/Reflux	□	□	Current/Recent Pregnancy	□	□	**Diabetes**
□	□	High Blood Pressure	□	□	Malignant Hyperthermia	□	□	**Do you smoke?**
□	□	Heart Disease	□	□	HIV/Hepatitis	□	□	**Bleeding Disorder**
□	□	Anemia	□	□	Lung/Breathing Problems	□	□	**Blood Clots/Swollen Legs**
□	□	**Recent use of Steroids/Prednisone**						
□	□	Any Other health problems_____						

ALLERGIES TO MEDICATIONS: _____

Please list **ALL** Medications you are currently taking below, or attach a copy:

_____
_____
_____
_____

Please list surgical history below (date and type of surgery)

_____
_____
_____
_____

Family History: Has anyone in your family had any of the following? (Blood relatives such Father, Mother, Siblings)

Yes	No		Yes	No	
□	□	Diabetes	□	□	Bleeding problems (clots or hemophilia)
□	□	Breast Cancer	□	□	Heart Disease

_____

Physical Assesment

HEART □ WNL _____ LUNGS □ WNL _____

ABDOMEN □ WNL _____ BREAST □ WNL_____

OTHER:_____

Physician Signature _____ Date _____