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	☐	☐	**Smoke/Vape/Use Nicotine**
☐	☐	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 _____