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	☐	☐	Bleeding Disorder	☐	☐	Thyroid Disease
☐	☐	Kidney Disease	☐	☐	Tumor, Cancer	☐	☐	Glaucoma/Porphyria
☐	☐	Diabetes	☐	☐	Seizures, Convulsions	☐	☐	Anesthesia problems
☐	☐	Hiatal Hernia/Reflux	☐	☐	Current/Recent Pregnancy	☐	☐	Psychiatric Disorder
☐	☐	High Blood Pressure	☐	☐	Malignant Hyperthermia	☐	☐	Do you smoke?
☐	☐	Heart Disease	☐	☐	HIV/Hepatitis	☐	☐	Rheumatoid Arthritis
☐	☐	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 hemophelia)
☐	☐	Breast Cancer	☐	☐	Heart Disease

Following to be completed by Doctor or Nurse:

Diabetes_____Recent Steroids_____Blood Clots_____Bleeding_____Smoking_____