



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 Assessment

HEART [] WNL _____ LUNGS [] WNL _____
ABDOMEN [] WNL _____ BREAST [] WNL _____
OTHER: _____

Physician Signature _____ Date _____