Jonathan D. Hall, M.D., F.A.C.S.
Hand and Plastic Surgery Specialists, Inc.

Patient's Name:_____ Date of initial visit: ___/_____/_____

Primary Care Physician: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Who Referred You/How Did You Hear About Us? _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Reason for Today's Visit: _____

Date of Injury or Onset of Illness: _____/_____/_____

Do You Smoke? _____ If so, how much? _____ Allergies: _____

Do You Drink? _____ If so, how much? _____

Drug Reactions? _____ Dominant Hand: _____

Anesthesia React: _____

Please list all **prescribed** medications which you are currently taking: _____

_____

Please list all **over-the-counter, herbal preparations, and vitamin supplements** which you are currently taking: _____

_____

PERSONAL MEDICAL HISTORY

Please check any of the following that apply and explain where necessary.

Diabetes ☐ _____

Cardiovascular Dis. ☐ _____

Blood Problems ☐ _____

High Blood Pressure ☐ _____

Bleed Easily ☐ _____

Recent Weight Change ☐ _____Height: _____Weight:_____ Loss ☐ Gain ☐

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Skin Problems ☐ _____

Psych. Problems ☐ _____

Present Treatment ☐ _____

Prior Med. Problems ☐ _____

Prior OB/GYN Problems ☐ _____

Pregnant ☐ _____

Children ☐ Names, Sex, Ages: _____
_____

Please list all past surgeries and/or hospitalizations: _____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

Diabetes: ☐

Kidney Disease: ☐

Heart Disease: ☐

Liver Disease: ☐

High Blood Pressure: ☐

Lung Disease: ☐

Skin Cancer: ☐

Arthritis: ☐

Breast Cancer: ☐

Mental Disorders: ☐

Other Cancer: ☐

Stroke: ☐