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: (   )__________________

Referred By: ______________________________________
Address: ______________________________________ City: ____________________
State: __________ Zip Code: ______________ Phone: (   )__________________

Reason for Today's Visit:____
Date of Injury or Onset of Illness: ____/____/____

Do You Smoke? Y☐ N☐ If so, how much?________ Allergies? Y☐ N☐__________
Do You Drink? Y☐ N☐ If so, how much?________
Drug Reactions? Y☐ N☐____________________ Dominant
Anesthesia React? Y☐ N☐____________________ Hand: Right☐ Left☐

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

Please list all **over-the-counter**, **herbal preparations**, and **vitamin supplements** which you are 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 Wt. Change? ☐ Height:__________ Weight:__________ Loss☐ Gain☐__________
Skin Problems? ☐____
Psych. Problems? ☐____
Present Treatment? ☐____
Prior Med. Prob.? ☐____
Prior OB/GYN Prob? ☐____
Pregnant? ☐____
Children? ☐Names, Sex, Ages:______________________________________

Please list all past surgeries and/or hospitalizations:______________________________
____
____

FAMILY MEDICAL HISTORY

Diabetes? ☐
Heart Disease? ☐
High Blood Pressure? ☐
Skin Cancer? ☐
Breast Cancer ☐
Other Cancer? ☐

Kidney Disease? ☐
Liver Disease? ☐
Lung Disease? ☐
Arthritis? ☐
Mental Disorders? ☐
Stroke? ☐