

**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:

Arthritis:

Kidney Disease:

Breast Cancer:

Heart Disease:

Mental Disorders:

Liver Disease:

Other Cancer:

High Blood Pressure:

Stroke:

Lung Disease:

Skin Cancer: