MEDICAL HISTORY

RESTORATION HAND AND PLASTIC SURGERY/MITCHELL FREMLING, M.D.,F.A.C.S.

Name: _____ DOB: ____/____/____ Sex: _____ Gender: _____

Occupation: _____ Number of children, if any: _____

Medical History: Please fill out **COMPLETELY** and use additional lines provided on the last page to add additional information if needed. if necessary.

1. What is your reason for seeing the doctor? _____

_____

_____

_____

_____

_____

2. What treatments have you already received for this problem? _____

_____

_____

_____

_____

_____

_____

3. Name of your Primary Care Physician: _____

4. Name of your Referring Physician: _____

5. Date of last physical exam: _____

6. Have you ever used Tobacco? ☐ Yes (☐ Cigarette ☐ Cigar ☐ Pipe ☐ Other) ☐ No
   If so, how much? _____ If you quit, what year? _____
   Passive smoke exposure? ☐ Yes ☐ No

7. Do you drink alcohol? _____ If so, how much? ☐ Daily ☐ Weekly ☐ Socially
   ☐ Beer ☐ Wine ☐ Other

8. Please check all that apply to you and provide additional information as needed in the space below:

GENITOURINARY-GYN
- ☐ Kidney/Bladder Infections
- ☐ Kidney Problems/Failure
- ☐ Kidney Stones
- ☐ Prostate Problems
- ☐ Chronic Kidney Disease
- ☐ Dialysis

NEUROLOGIC
- ☐ Stroke
- ☐ Seizure
- ☐ Psychiatric Treatment or Evaluation
- ☐ Numbness (specify below)
- ☐ Weakness (specify below)
- ☐ Depression
- ☐ Anxiety
- ☐ Parkinson's disease

HEMATOLOGIC
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Blood Transfusions
- ☐ Blood Clots
- ☐ Excessive Bruising

ENDOCRINE
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Prediabetes
- ☐ Thyroid disorder

CARDIAC/VASCULAR
- ☐ Angina/Chest Pain
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Valve Problems
- ☐ Pacemaker/AICD
- ☐ Arterial Insufficiency
- ☐ Venous Stasis Disease
- ☐ Swelling of the Ankles
- ☐ Atrial Fibrillation

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Pneumonia
- ☐ Pulmonary Embolism
- ☐ Shortness of Breath
- ☐ Recent Upper Respiratory Infection
- ☐ Sleep Apnea

DIGESTIVE (STOMACH)
- ☐ Ulcer
- ☐ Rectal Bleeding
- ☐ Hemorrhoids
- ☐ Hiatal Hernia/Reflux
- ☐ Colostomy
- ☐ Unplanned Weight Loss
- ☐ Unplanned Weight Gain

INTEGUMENT
- ☐ Skin Condition
- ☐ Excessive Scar (Keloid)
- ☐ Sun Damage
- ☐ Skin Breakdown/Ulcer
- ☐ Difficulty Healing
- ☐ Rashes/Psoriasis

INFECTIONS
- ☐ HIV/AIDS
- ☐ HIV Exposure
- ☐ Immune Problems
- ☐ Jaundice (Yellow Skin)
- ☐ Cirrhosis (Liver Failure)
- ☐ IV Drug Use
- ☐ Recurrent Infections
- ☐ Chemotherapy
- ☐ Hepatitis C
- ☐ Hepatitis B

MUSCULOSKELETAL
- ☐ Neck/Back Problems
- ☐ Broken Bones (specify)
- ☐ Torn Ligaments (specify)
- ☐ Bone Disorder
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Lupus
- ☐ Scleroderma

OPHTHALMOLOGIC
- ☐ Vision Problems
- ☐ Eye Disease
- ☐ Itching/Burning/Tearing

CANCER

Specify Sites/Type: _____ _____ _____

_____ _____ _____

9. List any operations: _____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

10. Please list your **current** medications, dosage and frequency (including over-the-counter medications, birth control, vitamins, & supplements):

☐ I am **not** currently taking any medications, over-the-counter medications, birth control, vitamins, or supplements.

☐ No Known Drug Allergies

11. Please list all allergies you have to drugs, tapes, ointments:	Reaction:

12. Please list any disease(s) that run in your family:

(Cancer, Diabetes, High Blood Pressure/Cholesterol, etc.)	Family Member:

13. Additional information: