

The Hand Center, P.A.

Name: _____ Age: _____ Referring Physician: _____

Dominant Hand (circle): Left Right Occupation: _____

Employer: _____

Injured side (circle): Left Right Both

What problem are you here to be treated for:

If this is an injury, list date of injury and how it happened:

If not an injury, when did your symptoms first appear? _____

Have you had any prior treatment (medication, splinting, therapy, surgery, etc.) or studies (X-rays, nerve tests, MRI/CT, etc.) related to this problem? Please list.

Is this injury work related? Yes No

Allergies/Medications:

List Allergies to Medications (and type of reaction if known)

List all Medications You Are Taking (including over-the-counter medication):

Medical History:

Please circle any of the following medical conditions that you are presently being treated for or have been treated for in the past.

Heart Attack	Liver Problems	Cancer	Lung problems
Heart Murmur	Hepatitis	Gout	Rheumatic Fever
Angina (chest pain)	Diabetes	Anemia	Drug Addiction
High Blood Pressure	Kidney Stones	Anxiety	Irregular heart beats
Blood Clots	Kidney failure	Stroke	Tuberculosis (TB)
Bleeding disorders	Urinary infections	HIV/AIDS	Seizures/epilepsy
Fibromyalgia	Thyroid Problems	Asthma	Artificial joints
Rheumatoid Arthritis	Ulcers	Depression	Osteoarthritis

Other medical illnesses or conditions you have: _____

CONTINUED ON REVERSE SIDE

Other physicians who are treating you:

Surgical History:

List all operations you have had performed (if known, include year and surgeon name)

Family History:

Please circle any of the following problems which affect your family members (brothers/sisters, parents, grandparents, etc.):

- Cancer Diabetes Bleeding Disorders High Blood Pressure
Strokes Arthritis Heart Problems Blood Clots
Depression Birth Defects Bone/Joint Problems Problems with Anesthesia
Other:

Social History:

Do you smoke? Yes No How many packs per day?
Do you drink alcohol? Yes No How much per week?
Have you abused drugs? Yes No What type?
Are you pregnant/nursing? Yes No Single Married Divorced Widow

Review of Systems: Circle if you have ever had any of the following symptoms:

- General: fever, weight loss, malaise, excessively tired, nausea
Eyes: double vision, blurred vision, trauma, visual changes
Ears, Nose, Throat: deafness, ringing in ears, hoarseness, dizzy, sinus problems
Heart, Vascular: chest pain, irregular beats, shortness of breath, swelling in legs
Lungs: asthma, cough, coughing blood, difficulty breathing lying flat
Intestines: loss of appetite, diarrhea, constipation, abdominal pain, vomiting
Urinary: difficulty urinating, incontinence, painful urination
Skeletal: joint swelling, joint pain, arthritis, fracture, loss of motion
Skin: skin or facial rashes, skin lesions, skin ulcers, warts
Neurologic: speech problems, numbness, weakness, loss of balance or memory
Psychiatric: depression, hallucinations, sleep problems, mood swings, crying spells
Endocrine: increased thirst/appetite, hair changes, growth change, hot/cold spells
Blood: abnormal bleeding, painful or enlarged lymph nodes, blood clots

I certify that the information I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the medical staff to perform any necessary medical services that I may need during diagnosis and treatment with my informed consent.

Patient's Signature Date