

# The Hand Surgery Center, P.A.

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Dominant Hand (circle): Left Right Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Injured side (circle): Left Right Both

What problem are you here to be treated for:

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

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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.

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Is this injury work related? Yes No

## Allergies/Medications:

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

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

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## 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:

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### Surgical History:

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

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### 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:	_____		

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### 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

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**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 \_\_\_\_\_