

HAND SURGICAL ASSOCIATES

Have you ever been diagnosed with the following?

YES NO

- Osteoporosis
- Arthritis
- Rheumatoid Arthritis
- Gout
- Diabetes
- Thyroid problems
- Heart disease
- High blood pressure
- Asthma
- Chronic lung disease
- Gastric reflux disease
- Stomach ulcers
- Bleeding disorders
- Phlebitis
- Epilepsy
- Anxiety
- Hepatitis
- Cancer – If yes, what type? _____

Have you had any significant problems in the past with the following?

YES NO

- Fevers/chills
- Chest pain
- Blood Clots
- Wheezing
- Heartburn
- Kidney stones
- Shingles
- Easy bleeding
- Seizures
- Tremor
- Depression

Do you have a family history of (circle and state which relative):

Relative(s) with problem

Osteoporosis _____
Dupuytren's Disease _____

List all your current medications:

Do you take any of the following?

YES NO

- Coumadin
- Daily Aspirin
- Plavix
- Vitamin E

List any allergies to medications:

Are you allergic to any of the following?

YES NO

- Penicillin
- Sulfa
- Latex

List all you prior surgeries: _____

Quantify these social activities:

Smoking: Never ½ pack/day 1 pack/day >1 pack/day

Alcohol: Never Rare Occasional Moderate Daily

What is your height? _____ What is your weight? _____

Your primary care doctor? _____ Who referred you for this visit? _____

Your age: _____ Right or left handed? _____ Male or Female? _____

Your occupation: _____

Circle the area (s) of the upper extremity is the doctor to examine today?

Please note:

- Circle the basic areas. We will review the details during your examination.
- Due to time and insurance restrictions, each exam is limited to 2 body areas or, if you need a referral, to the area requested in your referral.

Is the reason for your visit related to an injury (such as a fall, cut, accident, or workman's compensation problem)? _____

If yes, what was the date of the injury? _____

Briefly, describe the injury: _____

Did it occur at work? _____

Did it occur related to a car or car accident? _____

Were you treated for the injury? _____

If yes, where? _____

What are your symptoms? _____

When did the symptoms start? _____

What makes it worse? _____

What makes it better? _____

Briefly describe the symptoms: _____

Has the condition been treated so far with:

Anti-inflammatory meds? _____

Splint? _____

Therapy? _____

Injections? _____

Other? _____

Have any tests been done? _____

What if any. Diagnosis has been given for your condition? _____

Right / Left	
Shoulder	R / L
Upper Arm	R / L
Elbow	R / L
Forearm	R / L
Wrist	R / L
Hand	R / L
Thumb	R / L
Fingers	R / L

(Space for staff use only)

Splinted? Reduction?

Skin? Sutured?

Tetanus? Abx?

Xrays & Dates?

N/T?

Prior?

Sx?

(Space for staff use only)

N/T?

Distribution?

Night sx?

Pain or N/T?

Prior?

Tests & Dates?

Patient accompanied by
(relationship):