



HAND AND MICROSURGERY ASSOCIATES, INC.
COLUMBUS HAND THERAPY, LLC.

PATIENT MEDICAL HISTORY – PLEASE PRINT CLEARLY

Date:	Last Name	First Name	Initial	Social Security #
Doctor <input type="checkbox"/> Dr. Cook <input type="checkbox"/> Dr. Kobus <input type="checkbox"/> Dr. Lubbers <input type="checkbox"/> Dr. Nappi <input type="checkbox"/> Other <input type="checkbox"/> Dr. Gowda			Therapist	

Date of Birth	Age	Gender. <input type="checkbox"/> Male <input type="checkbox"/> Female	Right or Left Handed? <input type="checkbox"/> Right <input type="checkbox"/> Left	Occupation	Date of Injury
Where were you injured? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Vehicle <input type="checkbox"/> Other			Location of Injury [Hand, Finger etc.] <input type="checkbox"/> Right <input type="checkbox"/> Left		How were you injured?

Current Medications (List All Prescription and Over-the-Counter Medications Including Vitamins, Herbs, Aspirin etc. & Include Dose & Frequency. Add additional sheet if needed.)

Medication	Dose	Freq.	Medication	Dose	Freq.

Allergies & Reactions to Medications, Food & Latex

Check ALL that Apply <input type="checkbox"/> No Known Drug Allergies <input type="checkbox"/> Latex <input type="checkbox"/> Food (specify) <input type="checkbox"/> Other (specify)			
Height	Weight	Have you ever had general anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had any problems with anesthesia? <input type="checkbox"/> No <input type="checkbox"/> Yes (describe)

Medical History - Please Check All That Apply and Explain Checked Items Below

Skeletal & Nerves <input type="checkbox"/> Arthritis <input type="checkbox"/> Elbow / Hand Injury <input type="checkbox"/> Neck <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Severe / Frequent Headaches <input type="checkbox"/> Shoulder	Heart & Lung <input type="checkbox"/> Asthma, Bronchitis, Emphysema <input type="checkbox"/> Chest Pain <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Coronary Heart Disease / Angina <input type="checkbox"/> Heart Attack <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Pacemaker <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Tuberculosis / Infectious Disease	Other <input type="checkbox"/> Anemia <input type="checkbox"/> Any Bleeding Disorder <input type="checkbox"/> Blood Clot <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Emotional/Psychological Problems <input type="checkbox"/> Epilepsy / Seizures <input type="checkbox"/> Stroke / TIA <input type="checkbox"/> Other
Explanation of Items Checked Above		

Surgical History - List Most Recent Surgery First.

Year	Surgery	Year	Surgery
Year	Surgery	Year	Surgery
Year	Surgery	Year	Surgery

Are you aware of your diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	What are your Goals / Expectations for your Therapy?
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Patient Signature or Representative	Staff Signature
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