Hand and Microsurgery Associates

Hand and Arm Therapy Specialists

CHIEF COMPLAINT (Reason for visit today): ______________________________

Date ______________________

Account # ______________________

Patient Name ______________________

DOB ____________ Sex ________

Date of Injury: ______________________

Duration of Symptoms: ______________________

Location of Injury: Left Right

Dominant Hand: Left Right

ALLERGIES:

Are you allergic to Latex?	Y	N
Are you allergic to metals?	Y	N
Drug Allergies?	Y(List)	N

____

____

FAMILY HISTORY:

Diabetes	Y	N
Cancer	Y	N
Heart Disease	Y	N
Bleeding Disorders	Y	N

Other: ______________________________

Are you currently experiencing any of the following? (Please Circle Y/N)

Fever	Y	N	Numbness/Tingling	Y	N	Joint Pain	Y	N
Chills	Y	N	Migraines	Y	N	Abdominal Pain	Y	N
Weight Loss	Y	N	Weakness	Y	N	Reflux	Y	N
Irregular Heartbeat	Y	N	Shortness of Breath	Y	N	Difficulty Swallowing	Y	N
Unusual Bruising	Y	N	Joint Swelling	Y	N	Excessive Bleeding	Y	N
Rashes	Y	N						

PAST MEDICAL HISTORY (Please Circle Y/N)

MRSA	Y	N	Cardiac Stents	Y	N	Ulcers	Y	N
Tuberculosis (TB)	Y	N	Defibrillator	Y	N	Thyroid Disease	Y	N
Hepatitis	Y	N	Murmur	Y	N	Liver Disease	Y	N
HIV	Y	N	Stroke	Y	N	Sleep Apnea	Y	N
Vancomycin-Resistant Enterococci	Y	N	Bleeding/Blood Thinners	Y	N	Do you use a C-PAP?	Y	N
			Artificial Joint(s)	Y	N			

CURRENT MEDICAL PROBLEMS (Please Check Y/N)

	N	Yes, <1 year	Yes, >1 year		N	Yes, <1 year	Yes, >1 year		N	Yes, <1 year	Yes, >1 year
Diabetes				Cancer				Osteoporosis			
Heart Condition				Circulation/Vascular Problems				Chronic Pain/Fibromyalgia			
High Blood Pressure				Peripheral Neuropathy				Psychological Condition			
Chest Pain				Double Vision				Dizziness/Faintness			
Stroke				Night Sweats/Pain				Head Injury			
Kidney Condition				Sexual Dysfunction				Obesity			
Blood Clot/DVT				Groin Numbness				Seizures			
Metal Implants/ Pacemaker				Bladder/Bowel Problems				Headaches			
								Fractures			

Do you use tobacco? YES NO If so, what type and how much? ___________________________

Do you drink alcohol? YES NO If so, how much and how frequently? _______________________

Do you have an Advance Directive, Medical Power of Attorney or Living Will? YES NO

If yes, please provide a copy for our office Date Document Received ____________________

Height _________________________ Weight ______________________________

Medications INCLUDE OVER THE COUNTER & SUPPLEMENTS	Dose	**ALL** Previous Surgeries	Year

On a scale from 0 to 10, 0 being “no pain” and 10 being “worst pain imaginable”, please rate:

Your pain at rest 0 1 2 3 4 5 6 7 8 9 10

Your pain with activity 0 1 2 3 4 5 6 7 8 9 10

Have you ever had an adverse reaction to anesthesia?

YES NO **Please explain** ____

Have you or a family member ever experienced high fever due to anesthesia (malignant hyperthermia)? YES NO

Patient Signature ____ Date _______________________

Physician Signature ____ Date _______________________