Hand and Microsurgery Associates

Hand and Arm Therapy Specialists

Patient Name: _____ **DOB**: _____ **Sex:** _____

Account #: _____
OFFICE USE ONLY

Employer: _____

Chief Complaint: (Reason for visit today): _____

Date of Injury/Duration of Symptoms, if no injury: _____

Location of Injury: Left Right

Dominant Hand: Left Right

ALLERGIES:

Latex? Y N Reaction: _____
Metals? Y N Reaction: _____
Iodine? Y N Reaction: _____
Surgical Tape/Band-Aids? Y N Reaction: _____
Drug Allergies? Y N (List below with Reaction):

_____
_____

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/CURRENT MEDICAL PROBLEMS (Please Circle or Check Y or N)

MRSA	Y	N	HIV	Y	N	Artificial Joint(s)	Y	N
Tuberculosis (TB)	Y	N	Blood Clot(s)	Y	N	Metal Implant(s)	Y	N
Hepatitis	Y	N	DVT	Y	N	Vancomycin-Resistant Enterococci	Y	N

	Y	N		Y	N		Y	N
Heart Condition: _____			Cancer-Type: _____			Chronic Pain/Fibromyalgia		
High Blood Pressure (HTN)			Diabetes (DM) Type I			Seizures		
High Cholesterol (HLD)			Diabetes (DM) Type II			Headaches/ Migraines		
Cardiac Stents			Thyroid Disease			Osteoporosis		
Pacemaker			Liver Disease			Dizziness/Faintness		
Defibrillator			Kidney Condition			Head Injury		
Murmur			Asthma			Double Vision		
Stroke			COPD			Fractures		
Chest Pain			Sleep Apnea			Obesity		
Bleeding/Blood Thinner(s)			Do you use C-PAP?			Night Sweats/Pain		
Circulation Problems			Do you use Bi-PAP?			Groin Numbness		
Vascular Problems			GERD/ Ulcers			Bladder/Bowel Problems		
Factor V			Crohn's			Autoimmune Disorder		
Lupus			Multiple Sclerosis (MS)			Other Condition Not Listed:		
Celiac Disease			Rheumatoid Arthritis (RA)			_____		

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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: INCLUDING OVER THE COUNTER SUPPLEMENTS	Dose	**SURGERIES:** PLEASE LIST ALL	Year

Preferred Pharmacy Location _____

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 _____

09.25.2025