THE HAND & WRIST CENTER
Specialists in diagnoses, rehabilitation and surgery

MEDICAL HISTORY FORM

PATIENT'S NAME: ______________________________ **TODAY'S DATE:** ____________

WHO IS YOUR PRIMARY CARE PHYSICIAN? TELEPHONE NUMBER: LOCATION/CITY:

______________________ ____________ ______________________

LIST ALL MEDICAL CONDITIONS DIAGNOSED BY A PHYSICIAN (INCLUDING THOSE YOU TAKE OR DO NOT TAKE MEDICATION FOR):

MEDICAL CONDITION:	DATE DIAGNOSED:	NAME OF TREATING PHYSICIAN:	LOCATION/CITY:

LIST ALL MEDICATIONS YOU ARE TAKING (INCLUDING VITAMINS/SUPPLEMENT, ETC.)

MEDICATION NAME:	FOR WHICH CONDITION?	DOSE:	PRESCRIBING PHYSICIAN:

PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING AND LIST ALL ALLERGIES YOU MAY HAVE (OR SUSPECT YOU MAY HAVE):

MEDICATIONS? YES ☐ NO ☐ ______________________

ANESTHETICS? YES ☐ NO ☐ ______________________

INJECTIONS? YES ☐ NO ☐ ______________________

LATEX RUBBER? YES ☐ NO ☐ ______________________

OTHER: ______________________

LIST ALL PAST SURGERIES:

LIST ALL PAST SURGERIES:	DATE PERFORMED:	SURGEON:	LOCATION/CITY:

LIST ALL PAST "HAND AND WRIST" INJURIES:	DATE OF INJURY:	TREATING PHYSICIAN:	LOCATION/CITY:

HAVE YOU EVER HAD ANY BLOOD TRANSFUSIONS? YES ☐ NO ☐

DO YOU SMOKE? ☐ YES IF YES, HOW OFTEN/HOW MUCH: ______________________

☐ NO IF NO, HAVE YOU EVER SMOKED (AND IF "YES" – HOW OFTEN): ______________________

PLEASE LIST ANY ADDITIONAL MEDICAL INFORMATION WE SHOULD BE AWARE OF:

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IF YOU REQUIRE ADDITIONAL ROOM TO WRITE,
PLEASE CONTINUE ON THE REVERSE SIDE OF THIS FORM OR SUBMIT ADDITIONAL SHEETS AS NEEDED.