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

MEDICAL HISTORY FORM

PLEASE COMPLETE ALL SECTIONS ON THIS FORM. WRITE "NONE" OR "N/A" IF SOMETHING IS NOT APPLICABLE.

PATIENT'S NAME: _____ **TODAY'S DATE:** _____

DOMINANT HAND: ☐ **RIGHT** ☐ **LEFT** **HEIGHT:** _____ (inches) **WEIGHT:** _____(lbs)

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):
***YOU MAY ATTACH YOUR OWN LIST TO THIS FORM (AND WRITE "SEE ATTACHED"). FOR ADDITIONAL SPACE, USE ANOTHER SHEET.

MEDICAL CONDITIONS:

_____ _____

_____ _____

_____ _____

_____ _____

LIST ALL MEDICATIONS YOU ARE TAKING (INCLUDING VITAMINS/SUPPLEMENT, ETC.)
***YOU MAY ATTACH YOUR OWN LIST TO THIS FORM (AND WRITE "SEE ATTACHED"). FOR ADDITIONAL SPACE, USE ANOTHER SHEET.

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

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

MEDICATIONS? ☐ NO ☐ YES _____

ANESTHETICS? ☐ NO ☐ YES _____

INJECTIONS? ☐ NO ☐ YES _____

LATEX RUBBER? ☐ NO ☐ YES _____

OTHER: _____

LIST ALL PAST SURGERIES: DATE PERFORMED: SURGEON: LOCATION/CITY:
***YOU MAY ATTACH YOUR OWN LIST TO THIS FORM (AND WRITE "SEE ATTACHED"). FOR ADDITIONAL SPACE, USE ANOTHER SHEET.

LIST ALL PAST "HAND AND WRIST" INJURIES: DATE OF INJURY: TREATING PHYSICIAN: LOCATION/CITY:
***YOU MAY ATTACH YOUR OWN LIST TO THIS FORM (AND WRITE "SEE ATTACHED"). FOR ADDITIONAL SPACE, USE ANOTHER SHEET.

MEDICAL HISTORY FORM (CONT.)

DO YOU SMOKE? ☐ **NO** ☐ **YES** (HOW OFTEN: _____)

CHECK APPLICABLE: ☐ **TOBACCO** ☐ **CIGARETTES** ☐ **CANNABIS** ☐ **VAPE**

LIST YOUR HOBBIES/SPORTS: _____

OCCUPATION (IF APPLICABLE): _____

REVIEW OF SYSTEMS: CHECK ALL THAT APPLY

GENERAL:	☐ Fatigue	☐ Unexpected Weight Loss		
EYES:	☐ Recent Visual Changes	☐ Other:		
EAR/NOSE/THROAT:	☐ Sore Throat	☐ Nasal Drainage or Congestion	☐ Ear Pain	☐ Other:
LUNGS:	☐ Cough	☐ Sputum	☐ Shortness of Breath	☐ Other:
HEART:	☐ Chest Pain	☐ Palpitations	☐ Other:	
STOMACH/INTESTINES:	☐ Abdominal Pain	☐ Nausea/Vomiting	☐ Incontinence	☐ Other:
URINARY:	☐ Problems Urinating	☐ Abnormal Discharge	☐ Incontinence	☐ Other:
HEMATOLOGY:	☐ Easy Bruising	☐ Clotting Disorder	☐ Anemia	☐ Other:
SKIN:	☐ Skin Rash	☐ Other:		
PSYCHIATRIC:	☐ Depression	☐ Anxiety	☐ Other:	
IMMUNE SYSTEM:	☐ Frequent Infections	☐ Other:		
BONES/JOINTS: (OTHER THAN HAND/WRIST)	☐ Joint Aches	☐ Back Pain	☐ Other:	

LIST ADDITIONAL MEDICAL INFORMATION WE SHOULD BE AWARE OF:

_____

_____

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____ **DATE:** _____