



HAND & WRIST ESTABLISHED PATIENT MEDICAL HISTORY UPDATE

Date of visit: ___ / ___ / ___ Who are you seeing today: _____

YOUR INFORMATION

Full name: _____	Height: _____	Weight: _____
Date of birth: ___ / ___ / ___	Hand dominance: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ambidextrous	

Primary care physician: _____

PLEASE INDICATE ANY NEW MEDICATIONS SINCE LAST VISIT

Are you currently, or will you be initiating, the use of Medical Marijuana for any reason? Yes No

Are you taking Aspirin or any other blood thinners? Yes No

Yes No I consent to securely pull my medications from the pharmacy database, and reconcile with the Medical Assistant

List all the medications you take, both prescription & nonprescription below:

No medications to list

See attached list of medications

Medication or Brand Name	Dose	Medication or Brand Name	Dose

YOUR ALLERGIES

No new allergies **Indicate all the allergies you have to medications and/or food & describe reaction below:**
Common reactions include – Anaphylaxis (Life Threatening), Hives, Itching, Nausea/Vomiting, Trouble Breathing

PLEASE INDICATE ANY NEW MEDICAL HISTORY SINCE LAST VISIT

No new relevant medical history

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Obesity	<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Heart disease: _____	<input type="checkbox"/> Diabetes – I or II	<input type="checkbox"/> Peripheral vascular disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Anxiety	<input type="checkbox"/> DVT/blood clots
<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Cancer– Type: _____	<input type="checkbox"/> Depression	<input type="checkbox"/> Stroke

Any additional medical history information: _____

SURGICAL HISTORY SINCE LAST VISIT

No new surgical history

<input type="checkbox"/> Hip replacement – RT/LT	Date: ___/___/___	<input type="checkbox"/> Fracture – Type: _____	Date: ___/___/___
<input type="checkbox"/> Knee replacement – RT/LT	Date: ___/___/___	<input type="checkbox"/> Pacemaker	Date: ___/___/___
<input type="checkbox"/> Shoulder/rotator cuff – RT/LT	Date: ___/___/___	<input type="checkbox"/> Open heart/by-pass	Date: ___/___/___
<input type="checkbox"/> Carpal tunnel – RT/LT	Date: ___/___/___	<input type="checkbox"/> Spine – type/level: _____	Date: ___/___/___
<input type="checkbox"/> Arthroscopy – Type: _____	Date: ___/___/___	<input type="checkbox"/> Other: _____	Date: ___/___/___

Any additional surgical information: _____

DIAGNOSTIC HISTORY SINCE LAST VISIT

Study	Date	Results
X-RAYS	___ / ___ / ___	
MRI/CT	___ / ___ / ___	
EMG/nerve conduction studies	___ / ___ / ___	
Myelogram	___ / ___ / ___	
Bone scan / DEXA scan	___ / ___ / ___	



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YOUR SOCIAL HISTORY

Tobacco Use: Current Former Never **If Current, have you ever tried to quit?** Yes No
 Type: _____ Packs/Day: _____ Years used: _____

Alcohol Use: Yes No Former **If Yes, select type:** Beer Wine Liquor
 Frequency: _____ Amount per sitting: _____ Last drink: _____

Which of the following drugs or substances, if any, have you used in the PAST? (Please check all that apply)
 None Cocaine Heroin Marijuana Other: _____

Are you PRESENTLY using any of the following drugs or substances? (Please check all that apply)
 None Cocaine Heroin Marijuana Other: _____

REVIEW OF SYSTEMS

All Negative Below **Check if you have any of the following:**

General	Cardiovascular	Metabolic	Skin
<input type="checkbox"/> Fever	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Rash
<input type="checkbox"/> Weakness	<input type="checkbox"/> Leg swelling/edema	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Skin infections
<input type="checkbox"/> Weight gain/loss (circle one)	<input type="checkbox"/> Syncope/fainting		<input type="checkbox"/> Skin lesions
Ears, Nose & Vision	Gastrointestinal (GI)	Neurological	Blood Disorders
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Facial pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bruising
<input type="checkbox"/> Headache	<input type="checkbox"/> Nausea	<input type="checkbox"/> Poor coordination	
<input type="checkbox"/> Vertigo/dizziness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Muscle weakness	
Respiratory	Urinary	Psychiatric	Immune System
<input type="checkbox"/> Dyspnea (difficulty breathing)	<input type="checkbox"/> Dysuria (difficulty urinating)	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Asthma
<input type="checkbox"/> Recent infections	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Depression	<input type="checkbox"/> Environmental allergies
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Hematuria (blood in urine)	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Food allergies

YOUR ATTESTATION

I attest that the information provided above is complete & accurate as it will be utilized as part of my care and treatment plan.

Patient signature: _____ **Date:** ____ / ____ / ____

If minor, guardian signature: _____ **Date:** ____ / ____ / ____

HAND & WRIST CONDITION

Patient name: _____

Date of birth ___/___/___

Today's date ___/___/___

Tell us about the reason for your visit today

What is the reason for your visit today?

When did this condition start (onset)?

Place of injury? Sports Home Auto Accident Workplace School Non-applicable

How often does the condition occur? Rare Intermittent Occasional Persistent

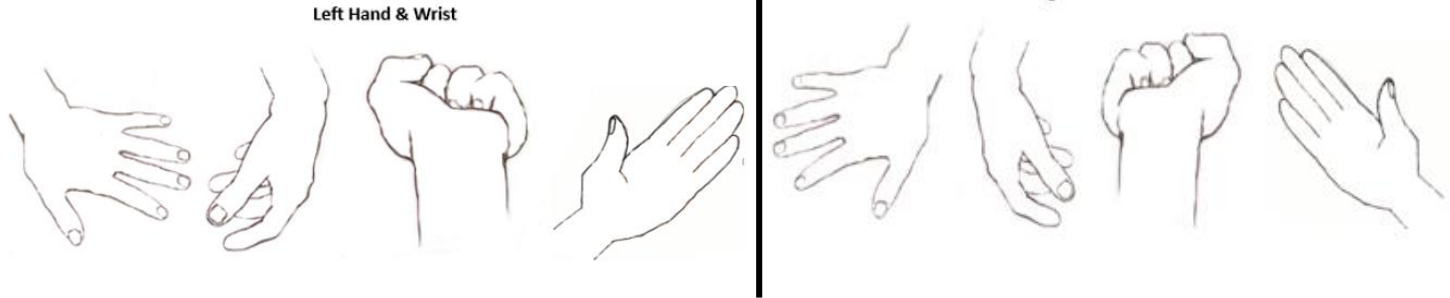
What is the status of your condition since the onset date? Unchanged Improving Fluctuating Stable Worse Resolved

What is the severity of your pain/numbness at its worst? (Circle a number) No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Incapacitating

What type of pain are you experiencing? Check all that apply.

- None Ache Burning Discomfort Dull Numbness Piercing Sharp
 Shooting Stabbing Electric Deep Throbbing Tearing Localized Diffuse

Location of Pain: *On the diagram below "SHADE" all areas where you feel pain and "X" the areas that hurt the most*



Is your condition aggravated by? Check all that apply

- Nothing Daily Activity Ascending stairs Descending stairs Jumping Kneeling Squatting
 Movement Physical therapy Lifting weight Pushing Bending Rotation/twisting Exercise
 Lying down Standing Sitting Sleeping Weather changes Walking Other: _____

Is your condition relieved by? Check all that apply

- Nothing Ice Heat Elevation Mobility Rest Stretching
 Exercise Brace Massage Physical therapy Injection Over the counter meds Pain medication

Tell us about your past medical history

<input type="checkbox"/> Never been treated for condition	Start Date	<input checked="" type="checkbox"/> Receiving now	End Date	Name of facility where treatment was completed	% of relief 0-100
Activity modification	___/___/___	<input type="checkbox"/>	___/___/___		
Bracing	___/___/___	<input type="checkbox"/>	___/___/___		
Injection/nerve block	___/___/___	<input type="checkbox"/>	___/___/___		
Drug/medication therapy	___/___/___	<input type="checkbox"/>	___/___/___		
Physical therapy	___/___/___	<input type="checkbox"/>	___/___/___		
Physician prescribed home exercise	___/___/___	<input type="checkbox"/>	___/___/___		
Resting the area	___/___/___	<input type="checkbox"/>	___/___/___		
TENS unit	___/___/___	<input type="checkbox"/>	___/___/___		
Other: _____	___/___/___	<input type="checkbox"/>	___/___/___		