

Name:							Date	e of B	irth:		M 🗆
Chief Complaint:	☐ Right	☐ Left] Both	☐ Hand	[Wr	ist	☐ Elbow	☐ Upper Extre	mity
History of Problem	:										
Duration (Length o	f Time):										
Intensity of Pain (S	cale 0-10; 0=N	No Pain, 10=	:Worst	Pain Im	aginable):						
Past treatment for	this problem: _										
Previous Surgeries											
									Date:		
Medical History (Ch	neck all medica		you ha		or currently	are b	eing '	treate Y	ed for):		
	lood Pressure		IN I	Strok	CP.		14	<u> </u>	Parkinson's D	isease	
- 	Disease/Heart A	Attack			Blood Clots				Multiple Sclerosis		
- 	ar Heart Rhyth				Diabetes				Seizure/Epilepsy		
	eral Vascular D				er				Nerve Injury		
- i i i i i i i i i i i i i i i i i i i	sema/COPD/A			Ulcer					Hepatitis	A B C	
Sleep /	Apnea			Kidne	ey Disease				Immunodefici	ency Disease (HIV)
Tuberculosis (TB)				Thyro	Thyroid Disease				Degenerative	iatica	
GERD Heartburn				Brain	Brain Injury				Arthritis/Osteo	oporosis	
Surgical History (Li	st all other sur	geries you h	ave h	ad):							
Year Type of Sui		jery		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Year			Туре	of Surgery		
List all Medications	s you take regu ne & Dose	ılarly (includ		-prescrip w Ofter					d List Dose	How 0	Hon
Ivali	IE & DUSE		пс	ow Oilei	'		IVA	IIIC O	DOSE	HOW O	11611
					I.s.						
	ORTHOPAED		RY		A T						
NE	HAND (CENTER	AIDE		 F						

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T-ENT -D

	Medication		Reaction	on		Medication	1		Reaction
ompl	ications (Check	and explain a	ny complication	is you have h	ad after a	ny of your su	rgeries):		
	Infection:		, ,			neumonia:	, , , , , , , , , , , , , , , , , , ,		
	Bleeding:				L	ung Problem	s:		
	Blood Clot:					Severe Nause		1	
	Anesthesia Rea	action:			C)ther:			
cial	History:								
oiai	· ilotor y ·								
cup	ation:							Full Time	☐ Part ☐ Re
	drink alaahal?		Vac If you have	w much0 🖂	4 F 🗆 G	. 10 🗆 11 :	15 🗆 16	00 🗆 00	or more driples/u
you	i uririk alconor?	□ NO □	res il yes, nov	w much? 🗀	1-5 🔲 6)-10 🔲 11-	15 🔲 16-	20 🗀 20	or more drinks/v
) VOL	currently smok	e? No	☐ Yes If v	yes, number o	of packs p	er dav:	F	or ye	ears
,								· , ·	
				, ,	· paiorio p	-			
d yo	u ever smoke?	□ No □ \					F	or ye	ears Year quit: _
			Yes If y	yes, number o	of packs p	er day:		-	•
				yes, number o	of packs p	er day:		-	•
-			Yes If y	yes, number o	of packs p	er day:		-	•
-			Yes If y	yes, number o	of packs p	er day:		-	•
story	of Substance A	buse? □N	Yes If y lo □ Yes If y	yes, number o	of packs p	er day:		-	•
story	of Substance A	buse? □N	Yes If y lo □ Yes If y cent/current pro	yes, number o yes, what sub oblems, check	of packs p	er day:		-	
story	of Substance A of Symptoms (System	buse? □N	Yes If y lo □ Yes If y cent/current pro Symptoms/Pr	yes, number o yes, what sub oblems, check roblems	of packs p stance: _ c symptor	er day:	other):		•
story	of Substance A of Symptoms (System General	buse? □N	Yes If y lo □ Yes If y cent/current pro Symptoms/Pr □ Fever, □	yes, number o yes, what sub oblems, check roblems Unexplained	of packs p stance: _ c symptor Weight L	ns or write in	other):		
story	of Substance A of Symptoms (System General Eyes/Vision	buse? □ N Check any re	Yes If y cent/current pro Symptoms/Pi □ Fever, □ □ Glasses,	yes, number of yes, what substitute of the subst	of packs p stance: _ x symptor Weight L _ Doubl	ns or write inoss/Gain,	other): Weaknes yes	S	
story	of Substance A of Symptoms (System General Eyes/Vision Ears, Nose, Ti	buse? □ N Check any re	Yes If y cent/current pro Symptoms/Pr ☐ Fever, ☐ ☐ Glasses, ☐ Vertigo,	yes, number of yes, what substitute oblems, check roblems Unexplained Blurred, Sinusitis,	stance: _ stance: _ weight L Doubl	ns or write in oss/Gain, [e, Dry Eseness, D	other): Weaknes yes Loss of Hea	s	Other
story	of Substance A of Symptoms (System General Eyes/Vision Ears, Nose, TI Heart	buse? □ N Check any re	res If y cent/current pro Symptoms/Pi Fever, Glasses, Uertigo, Chest Pain	yes, number of yes, what substitute oblems, check roblems Unexplained Blurred, Sinusitis,	stance: _ stance: _ symptor Weight L Doubl Hoars	ns or write in oss/Gain, e, Dry Eseness, Calpitations,	other): Weaknes yes Loss of Hea	s aring ar Rhythm	Other
story	of Substance A of Symptoms (System General Eyes/Vision Ears, Nose, TI Heart Lung	buse? □ N Check any re	res If y cent/current pro Symptoms/Pr Fever, Glasses, Vertigo, Chest Pain Short of Br	yes, number of yes, what substitute of the subst	stance: _ stance: _ weight L DoubleHoars rs, F	ns or write in oss/Gain, e,	other): Weaknes yes Loss of Hea Irregul	s aring ar Rhythm	Other
story	of Substance A of Symptoms (System General Eyes/Vision Ears, Nose, TI Heart Lung Circulation	buse?	cent/current pro Symptoms/Pi Fever, Glasses, Uertigo, Chest Pain Blood Clots	yes, number of yes, what substitute oblems, check roblems Unexplained Blurred, Sinusitis, Murmureath, Seath, Swelling	stance: _ stance: _ Weight L Double Hoars Irs,	ns or write in oss/Gain, [e, Dry Eseness, Dalpitations, Claudication,	other): Weaknes yes Loss of Hea Irregul Wheezing Varico	s aring ar Rhythm	Other
story	of Substance A of Symptoms (System General Eyes/Vision Ears, Nose, TI Heart Lung Circulation Digestive Trace	buse?	cent/current pro Symptoms/Pi Fever, Glasses, Uertigo, Chest Pain Blood Clots	yes, number of yes, what substitute of the subst	stance: _ stance: _ Symptor Weight L Doubl Hoars Irs, F thma, [ng, C tion, C	oss/Gain, [e, Dry Eseness, Dalpitations, Claudication, Ulcers, Dry Eseres, Dalpitations, Dalpitation, Dalpita	weaknes yes Loss of Hea Irregul Wheezing Varico GERD,	s aring ar Rhythm) sities	Other
story	of Substance A of Symptoms (System General Eyes/Vision Ears, Nose, TI Heart Lung Circulation	buse?	cent/current pro Symptoms/Pi Fever, Glasses, Vertigo, Chest Pain Short of Br Blood Clots Diarrhea, Stones,	yes, number of yes, what substitute oblems, checkeroblems Unexplained Blurred, Sinusitis, Hurmureath, Seath, Swelling Constipation	stance: _ Stance	ns or write in oss/Gain, e, Dry E seness, Calpitations, Claudication, Ulcers, Calpication, Ulcers, Calpication	weaknes yes Loss of Hea Irregul Wheezing Varico GERD,	s aring ar Rhythm) sities	Other
story	of Substance A of Symptoms (System General Eyes/Vision Ears, Nose, TI Heart Lung Circulation Digestive Track Kidney/Urinar	buse?	cent/current pro Symptoms/Pi Glasses, Glasses, Chest Pain Short of Br Blood Clots Diarrhea, Stones, Rash, Lum	yes, number of yes, what substitute of the subst	stance: _ stance: _ stance: _ stance: _ Symptor Weight L Doubl Hoars Irs,	ns or write in oss/Gain, e, Dry E seness, Calpitations, Claudication, Ulcers, Ulcers, G, Bleed air or Nails Ch	weaknes yes Loss of Hea Irregul Wheezing Varico GERD,	s aring ar Rhythm) sities	Other
istory	of Substance A of Symptoms (System General Eyes/Vision Ears, Nose, TI Heart Lung Circulation Digestive Track Kidney/Urinar Skin/Breast	buse?	cent/current pro Symptoms/Pr Fever, Glasses, Vertigo, Chest Pain Short of Br Blood Clots Diarrhea, Stones, Rash, Lum Excess Thi	yes, number of yes, what substitute of the section	stance: _ stance: _ stance: _ weight L Double Hoars rs,	ns or write in oss/Gain, e,	weaknes yes Loss of Hea Irregul Varico GERD, ing nange abetes	s aring ar Rhythm g sities Pain	Other
story	of Substance A of Symptoms (System General Eyes/Vision Ears, Nose, TI Heart Lung Circulation Digestive Trace Kidney/Urinar Skin/Breast Endocrine Neurologic	buse?	cent/current pro Symptoms/Pi Symptoms/Pi Glasses, Chest Pain Short of Br Blood Clots Diarrhea, Stones, Rash, Lum Excess Thi Balance,	yes, number of yes, what substitute of the section	stance: _ stance: _ stance: _ Symptor Weight L Doubl Hoars Irs, F thma, G ion, G Itching g, Ha reased En s/Tingling	ns or write in oss/Gain, e,	weaknes yes Loss of Hea Irregul Wheezing Varico GERD, ing nange abetes e, Trei	s aring ar Rhythm g sities Pain	Other
istory	of Substance A of Symptoms (System General Eyes/Vision Ears, Nose, TI Heart Lung Circulation Digestive Track Kidney/Urinar Skin/Breast Endocrine	Check any re	cent/current pro Symptoms/Pr Symptoms/Pr Glasses, Chest Pain Short of Br Blood Clots Diarrhea, Stones, Rash, Lum Excess Thi Balance, Depressior	yes, number of yes, what substitute of the subst	stance: _ stance: _ stance: _ Symptor Weight L Double Hoars rs, F thma, F thma, G ng, C cion, Ha reased En s/Tingling tty, S	ns or write in oss/Gain, e,	weaknes yes Loss of Hea Irregul Wheezing Varico GERD, ing nange abetes e, Trei	s aring ar Rhythm g sities Pain	Other

ORTHOPAEDIC SURGERY
HAND CENTER
NEW PATIENT QUESTIONNAIRE

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PAT-EXT -D

Family History (Mark any conditions that your parents or siblings have or have had by indicating the family member [M = mother, F = Father, B = Brother, S = Sister] after the conditions):

Cancer:

Asthma:

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Heart Attack:	Lung Disease:	Stroke:	
Coronary Artery Disease:	Tuberculosis:	Diabetes:	
Heart Valve Disease:	Thyroid Disease:	Kidney Disease:	
Irregular Heart Rhythm:	Blood Clots:	Arthritis:	
Peripheral Vascular Disease:	Seizures:	Osteoporosis:	
Hepatitis: ☐ A ☐ B ☐ C	Immunodeficiency:		
I certify that the foregoing statements are t	rue to the best of my knowledge.		
Patient Signature:		Date:	Time:
Physician (Print):	(Signature):	Date:	Time:
Vital Signs:			
Temp: BP: HR:	RR: Pain: Height:	Weight:	BMI:
Medical Assistant (Print):			

ORTHOPAEDIC SURGERY
HAND CENTER
NEW PATIENT QUESTIONNAIRE

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PATIENT ID

High Blood Pressure: