Northshore Healthcare/Ohio Hand Center

PATIENT HISTORY FORM

Name____ Date of birth _____ /____ /_____ Age ______

Date____________________ Height___________________ Weight_____________________

Primary Care Physician____

Referring Physician____

Why are you seeing the doctor today? ____

When did the problem begin? ____

Was it related to an accident? ☐ No ☐ Yes If yes, date of injury___________ Date last worked___________

Are you obtaining workers compensation for this injury? ☐ No ☐ Yes

Are you involved in any lawsuits pertaining to this injury? ☐ No ☐ Yes

Pain Severity: **Please Circle** None **0 1 2 3 4 5 6 7 8 9 10 Extreme**

What activities make the pain **worse**?

____

What activities make the pain **better?** (Including treatments)

____

Have you had any prior surgery to this area? ☐ Yes ☐ No
If yes, when? ___________________________ Where? ____
By whom? ____
===

Do you have any allergies to medications? ☐ No ☐ Yes If YES, please list:

____

____

Current medications, including vitamins and herbal supplements___________________________________

____

____

____

Are you taking or have you ever taken blood thinners? ☐ Yes ☐ No

Stomach pain when taking anti-inflammatories? ☐ Yes ☐ No

Please list any surgeries you have had and the approximate year: ____________________________________

____

____

>>>>>>>> Please complete both sides of form. Thank you. <<<<<<<<

OFFICE USE ONLY

Reviewed Page1 & 2: _________________/_________________/_________________/_________ BMI _______

Date: __________________/_________________/__________________/__________________

Medical History/Review of Systems

☐ Anemia	☐ Stomach Ulcer	☐ Connective Tissue Disorder	☐ Gout
☐ Bipolar Disorder	☐ TIA/Stroke	☐ Heart Valve Disease	☐ Fibromyalgia
☐ Psoriasis	☐ Thyroid Disease	☐ Irregular Heart Beat	☐ Fracture
☐ Frequent Rash	☐ Seizure Disorder	☐ Heart Attack	☐ Incontinence
☐ Weight Gain	☐ Emphysema	☐ Chest Pain	☐ Kidney Failure
☐ Weight Loss	☐ COPD	☐ High Cholesterol	☐ Kidney Stones
☐ Poor Vision	☐ Parkinson's Disease	☐ Blood Transfusion	☐ Osteoarthritis
☐ Hearing Loss	☐ Sickle Cell Disease	☐ Pacemaker/Defibrillator	☐ Osteoporosis
☐ Fever	☐ Asthma	☐ High Blood Pressure	☐ Painful Urination
☐ Diarrhea	☐ HIV/AIDS	☐ Infection After Surgery	☐ Pregnant
☐ Skin Ulcers	☐ Hepatitis	☐ Heart Burn	☐ Prostate Disease
☐ Depression/Anxiety	☐ Multiple Sclerosis	☐ Bleeding Disorder	☐ Rheumatoid Arthritis

Are you diabetic? ☐ No ☐ Yes If YES, controlled with: ☐ Diet ☐ Oral Medications ☐ Insulin

History of blood clots? ☐ No ☐ Yes If YES: ☐ Leg ☐ Lung ☐ Other______________________________

Cancer history____

Treatment(s) ____

Other medical history **not** listed above____

____

List any problems with anesthesia____

Have you ever had a bone density scan (Dexa scan)? ☐ No ☐ Yes If YES, when? ___________________

Where? ____

Social History

Occupation: _________________________________ ☐ Currently working ☐ Retired _________________

Living arrangements ☐ Live alone ☐ Married ☐ Live w/parents ☐ Live w/adult children

☐ Nursing Home ☐ Other ____

Do you drink alcoholic beverages? ☐ Never ☐ Rarely ☐ Socially ☐ Moderately ☐ Heavily ☐ Recovering

Do you smoke? ☐ No ☐ Yes If yes, how many packs per day? ________ ☐ Quit (year) ________ ☐ Never

Do you use recreational (street) drugs? ☐ No ☐ Yes If yes, list drug and last date of use? _________________

Are you being treated with Suboxone? ☐ Yes ☐ No

To the best of my knowledge all the preceding answers are true and correct. If I have any change in my medical history, I will inform Ohio Hand Center at my next appointment, or by phone if no visits are scheduled. I understand that failure to disclose my medical condition may jeopardize my health.

Patient's Signature: ____ Date: __________________________

(Parent/Legal guardian if patient is a minor)