

CAROLINA HAND AND SPORTS MEDICINE

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Age: _____ Sex: M F Height: _____ Weight: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Referring Physicians Name: _____ Hand Dominance: Left Right

Part of body being seen for today: R L _____

In this section, check the box which best describes how your problem started . Please answer the questions related to the box you checked.	
<input type="checkbox"/> NO INJURY Was the onset <input type="checkbox"/> Gradual <input type="checkbox"/> Sudden Onset date or Duration: _____ <input type="checkbox"/> INJURY <input type="checkbox"/> Accident <input type="checkbox"/> Sport Date of Injury: _____ <input type="checkbox"/> INJURY AT WORK Date of Injury: _____ <input type="checkbox"/> Lift <input type="checkbox"/> Twist <input type="checkbox"/> Fall <input type="checkbox"/> Bend <input type="checkbox"/> Pull <input type="checkbox"/> Reach <input type="checkbox"/> Repetitive <input type="checkbox"/> AUTO ACCIDENT Date: _____	Description of Injury/Accident/Problem: _____ _____ _____ _____ _____

Have you had a problem like this before? N Y

Were you seen anywhere for this problem? N Y Location: _____

What test scans have you had for this problem? X-rays MRI CT SCAN Bone Scan Nerve Test (EMG/NCV)

On a scale of 0-10 (10 is the worst) how severe is your pain, today? 0 1 2 3 4 5 6 7 8 9 10

What is the quality of pain? Sharp Dull Stabbing Throbbing Aching Burning

The pain is: Constant Intermittent (comes and goes) **Does the pain wake you from sleep?** N Y

I experience: Swelling Bruising Numbness Tingling Weakness Locking/Catching Giving way
 Pain Stiffness Other: _____

Since my problem started, it is: Getting Better Getting Worse Unchanged

What makes your symptoms worse: Standing Walking Lifting Twisting Stairs Exercise
 Squatting Kneeling Sitting

What makes your symptoms better?: Rest Elevation Ice Heat Other: _____

PAST MEDICAL HISTORY

List ALL Previous Surgeries: <input type="checkbox"/> NONE	YEAR:
_____	_____
_____	_____
_____	_____

Are you taking, or have you ever taken, blood thinners? N Y If yes, which one? _____

List any medications you are taking on a regular basis (including hormonal replacement therapy or birth control) :	
<input type="checkbox"/> NONE	Medication: _____ _____ _____ _____ _____
	Reason: _____ _____ _____ _____ _____

Patient Name: _____

PAST MEDICAL HISTORY

Are you allergic to any medications? <input type="checkbox"/> N <input type="checkbox"/> Y If yes, please list below	
Medication Allergies: _____ _____ _____	Reactions: _____ _____ _____
Other Allergies? <input type="checkbox"/> N <input type="checkbox"/> Y If yes, what are they? _____ LATEX ALLERGY <input type="checkbox"/> N <input type="checkbox"/> Y	

Do you have a personal history or any of the following? <input type="checkbox"/> NONE			
<input type="checkbox"/> Stroke	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Continuous Seizures	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Bone or Joint Infections	<input type="checkbox"/> Problems with wound healing	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Blood Pressure	<input type="checkbox"/> Sleep Apnea Use a CPAP? <input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> Asthma
<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Blood Disorder Type: _____	<input type="checkbox"/> Dialysis
<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Heart Disease/Defect	<input type="checkbox"/> Hepatitis Type: _____	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Alcohol Dependency	<input type="checkbox"/> Arthritis Type: _____	<input type="checkbox"/> Pain Pump
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Drug Dependency	<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Neurostimulator
Are you Pregnant? <input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> Chemotherapy/Radiation	<input type="checkbox"/> Reaction to Anesthesia	<input type="checkbox"/> MRSA history
Claustrophobic? <input type="checkbox"/> N <input type="checkbox"/> Y	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Cancer Type: _____	

REVIEW OF SYSTEMS

HAVE YOU HAD PROBLEMS IN THE PAST 6 MONTHS?					NONE	COMMENTS
1) GI	<input type="checkbox"/> Heartburn, Ulcers	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Blood in Stool		<input type="checkbox"/>	
2) ENDO	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Cold Intolerance		<input type="checkbox"/>	
3) CON	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Fatigue		<input type="checkbox"/>	
4) EYE	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Vision Loss		<input type="checkbox"/>	
5) ENT	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Trouble Swallowing		<input type="checkbox"/>	
6) CV	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations			<input type="checkbox"/>	
7) RS	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Shortness of Breath		<input type="checkbox"/>	
8) GU	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Kidney Problems		<input type="checkbox"/>	
9) SK	<input type="checkbox"/> Frequent Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Lumps	<input type="checkbox"/> Psoriasis	<input type="checkbox"/>	
10) NEU	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness	<input type="checkbox"/>	
11) PSY	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Alcohol Addiction	<input type="checkbox"/> Sleep Disorder	<input type="checkbox"/>	
12) HEM	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Anemia		<input type="checkbox"/>	

FAMILY HISTORY

HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING DISORDERS? <input type="checkbox"/> ADOPTED <input type="checkbox"/> UNKNOWN						
FATHER:	<input type="checkbox"/> None	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anesthesia Problems	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Rheumatoid Arthritis
MOTHER:	<input type="checkbox"/> None	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anesthesia Problems	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Rheumatoid Arthritis
SIBLINGS:	<input type="checkbox"/> None	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anesthesia Problems	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Rheumatoid Arthritis

SOCIAL HISTORY

Do you use tobacco? N Y **If yes, cans/packs per day** _____ QUIT

Alcohol use? N Y QUIT

Marital History: Married Single Divorced Widowed

Are you currently working? N Y **If no, when did you last work?** _____
 Retired Disabled **If disabled, what is your disability?** _____

Are you currently on any work restrictions? N Y **If yes, what are they?** _____

Occupation: _____ **Employer** _____ STUDENT

Signature _____ Date _____