

CENTER FOR HAND & EXTREMITY RECONSTRUCTIVE SURGERY, PLC

MEDICAL HISTORY FORM

Describe your symptoms: _____

Which hand/arm? RIGHT LEFT (CIRCLE ONE OR BOTH IF BILATERAL)

Did your condition come on gradually? YES NO

Was there an accident involved? YES NO

If yes: Date _____ Describe the accident/circumstance _____

PAST MEDICAL HISTORY:

- High Blood Pressure? Y N
- Diabetes? Y N
- Heart Attack? Y N
- Thyroid Problems? Y N
- Disorders of the Nervous System? Y N
- Liver/Kidney problems? Y N
- Tumors? Y N
- Stomach Ulcers? Y N
- Artificial Heart Valve? Y N
- Artificial Joints? Y N
- Other Surgical Implants? Y N

SOCIAL HISTORY

- Do you smoke cigarettes? Y N
- If yes, how many packs per day? ____
- Do you drink alcohol? Y N If yes, occasional__ moderate__ excessive__
- Job _____
- Education _____

• **REVIEW OF SYSTEMS:** any current problems in the following areas:

- Ears, eyes, nose, mouth? Y N
- Fever, weight loss, feeling ill? Y N
- Bleeding tendency or blood thinners? Y N
- Clotting Tendency? Y N
- Bone or joint? Y N
- Neurological? Y N
- Sleep problems? Y N
- Heart? Y N
- Lung? Y N
- Thyroid? Y N
- Diabetes? Y N
- Hormonal? Y N
- Bowel or Bladder? Y N
- Are you pregnant? Y N
- Skin Problems? Y N
- Psychiatric problems? Y N

SURGICAL HISTORY: Please list any prior surgeries: _____

ARE YOU CURRENTLY BEING TREATED FOR ANY OTHER CONDITIONS: _____

CURRENT MEDICATIONS: (including vitamins, supplements and include dose): _____

ANY ALLERGIES TO MEDICATIONS: _____

FAMILY HISTORY: Does any member of your immediate family have any bone or joint disorders? Y N

Describe: _____