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.

☐ **NO INJURY** Was the onset ☐ Gradual ☐ **Sudden** **Onset date or Duration:**_____ ☐ **INJURY** ☐ Accident ☐ Sport **Date of Injury**:_____ ☐ **INJURY AT WORK** **Date of Injury**:_____ ☐ Lift ☐ Twist ☐ Fall ☐ Bend ☐ Pull ☐ Reach ☐ Repetitive ☐ **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: ☐ **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) :

☐ **NONE**	**Medication:**	**Reason:**

Patient Name: _____

PAST MEDICAL HISTORY

Are you allergic to any medications? ☐ **N** ☐ **Y** **If yes, please list below**	
Medication Allergies:	**Reactions:**
_____	_____
_____	_____
_____	_____
_____	_____
Other Allergies? ☐ **N** ☐ **Y** **If yes, what are they?** _____	**LATEX ALLERGY** ☐ **N** ☐ **Y**

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

REVIEW OF SYSTEMS

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

FAMILY HISTORY

HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING DISORDERS? ☐ **ADOPTED** ☐ **UNKNOWN**						
FATHER:	☐ None	☐ Diabetes	☐ Anesthesia Problems	☐ High Blood Pressure	☐ Bleeding Problems	☐ Rheumatoid Arthritis
MOTHER:	☐ None	☐ Diabetes	☐ Anesthesia Problems	☐ High Blood Pressure	☐ Bleeding Problems	☐ Rheumatoid Arthritis
SIBLINGS:	☐ None	☐ Diabetes	☐ Anesthesia Problems	☐ High Blood Pressure	☐ Bleeding Problems	☐ 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**