



Previous Patient



The Hand Center  
OF WATERBURY



Appointment Date & Time: \_\_\_\_\_  
Entered in EMRge: \_\_\_\_\_

# New Patient Medical Survey Form

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

### How did you hear about our office?

- Dr. \_\_\_\_\_ Is this your primary doctor?  Yes  No – Who is your primary doctor? \_\_\_\_\_
- Friend/Family  Insurance Company  Attorney: \_\_\_\_\_  Workers Comp: \_\_\_\_\_  Auto Injury
- Yellow Pages  Print Advertising  ER: \_\_\_\_\_  Other: \_\_\_\_\_

### EMPLOYMENT INFORMATION

Are you currently employed?  Yes  No  Retired  Student

Permanent Disability  Temporary Disability If **disabled**, for what? \_\_\_\_\_

Is this a work-related injury?  Yes  No

If working, who is your employer? \_\_\_\_\_ For how long? \_\_\_\_\_

Please describe your job (or former job) \_\_\_\_\_

If you stopped working, when did you stop? \_\_\_\_\_

### CHIEF COMPLAINT

When did your symptoms begin/Date of injury? \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

● Are you **RIGHT** or **LEFT** handed?  RIGHT  LEFT  AMBIDEXTROUS - Writes with \_\_\_\_\_ hand

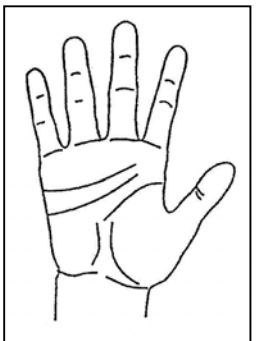
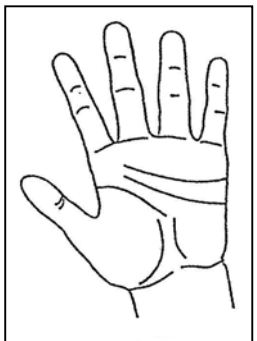
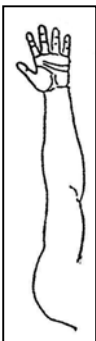
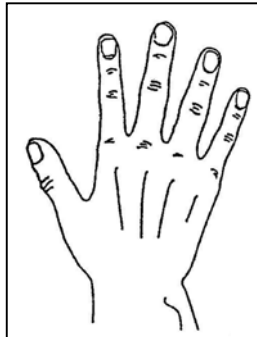
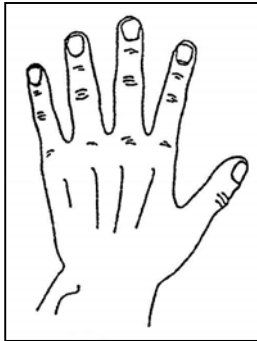
On the diagrams below, please identify where your problem is:

LEFT ARM

LEFT HAND

RIGHT HAND

RIGHT ARM *Physician's Notes:*



**PAGE 2**

If both **RIGHT** and **LEFT** sides are affected, which is worse?  RIGHT  LEFT  EQUAL

How bad is your pain – circle one number: (not bad) 1 2 3 4 5 6 7 8 9 10 (worst pain I've ever had)



Are you getting better?  Better  Worse  Staying the same for a while

**How** did your symptoms begin? \_\_\_\_\_

Have you ever had this problem or these symptoms before?  No  Yes - Describe: \_\_\_\_\_

Have you ever injured this area before?  No  Yes - Describe: \_\_\_\_\_

Have you had any **tests** for this problem? (If you are completing this at home, please bring copies of any tests to your first appt.)

Test	No	Yes	When?	Where?	(Staff Use)
X-Rays					
MRI					
CT Scan					
Nerve Study					
Other (list):					

Have you seen another **Doctor** for this problem?  No  Yes – List: \_\_\_\_\_

Have you had any **treatment** for this problem?

- Splints  No  Yes - Type of splint/use: \_\_\_\_\_
- Therapy  No  Yes - Where: \_\_\_\_\_ When was your last therapy visit? \_\_\_\_\_
- Medication for this problem  No  Yes - List: \_\_\_\_\_ Date last used: \_\_\_\_\_
- Other: \_\_\_\_\_

Is your pain:  constant  intermittent (comes and goes)  sharp  dull  aching  pounding  other: \_\_\_\_\_  
 associated with a particular activity? Please list: \_\_\_\_\_

If your pain is intermittent, **when** do your symptoms occur?

- night  morning  during activity  after activity
- work  cold  neck movement  other: \_\_\_\_\_

What makes your symptoms **worse**?  Not applicable

- rest  therapy  heat  cold  brace/splint  exercise  other: \_\_\_\_\_
- work/activity – be specific: \_\_\_\_\_

What makes your symptoms **better**?  Not applicable

- rest  therapy  heat  cold  brace/splint  exercise  other: \_\_\_\_\_
- medications – Please list: \_\_\_\_\_

Do you have pain in any other joints in your body?  No  Yes - List: \_\_\_\_\_

**MEDICAL & FAMILY HISTORY**

Please check the items that apply to you

Please check the items that apply to your family members

	No	Yes	<i>Physician's Notes</i>	Mother	Father	Sister	Brother	Grandparent
Bleeding Disorders								
Heart Problems (see below)								
Breathing Problems								
Anesthesia Problems								
Arthritis								
Broken Bones								
Stomach Problems								
Intestinal Prob's								
Allergy Problems								
Kidney Problems								
Thyroid Problems								
Neuro. Problems								
Stroke								
Cancer – what type?								
Diabetes								
Cholesterol Problems								
High Blood Pressure								
Dupytren's								
Other:								
Other:								

Do **you** have a heart problem?  No  Yes - please describe:

- Heart Attack (MI)   
  Congestive Heart Failure (CHF)   
  Stents   
  Irregular Beat/Palpitations   
  Murmur  
 Coronary Artery Bypass Grafting (CABG)   
  Mitral Valve Prolapse (MVP)   
  "Water on the lung"

Have you ever had any unusual infections?

- No   
  Yes:   
 Tuberculosis   
 Pneumonia   
 Mycobacterium   
 Other: \_\_\_\_\_

Have you been living with anyone in the past 2 years who has been diagnosed with Tuberculosis (TB?)  No  Yes

Are you experiencing peri-menopause?  N/A  No  Yes - Did you use any medications? (circle) YES NO

Have you gone through menopause?  N/A  No  Yes - Did you use any medications? (circle) YES NO

**SURGICAL HISTORY**

Please identify all the surgery that you have had. If you recall the date and doctor, please list them:

<b>Surgery</b>	<b>None</b>	<b>Yes</b>	<b>Type of Surgery</b>	<b>Right/Left</b>	<b>Date/Year</b>	<b>Doctor</b>
Arm or Hand Surgery						
Cardiac/Heart				NA		
Neck				NA		
Back				NA		
Knee						
Hip						
Other Orthopaedic						
Other Orthopaedic						
Tonsillectomy				NA		
Appendectomy				NA		
Gall Bladder				NA		
Breast						
Other OB-Gyn						
Hysterectomy				NA		
Prostate/Other				NA		
Laparoscopy				NA		
Other:						
Other:						

**MEDICINES**

Please list your current medications (both prescription & over the counter,) vitamins, aspirin, etc.  
 – we will photocopy your list:

<b>Prescription Medication</b>	<b>Dose/Frequency</b>	<b>Prescribing Doctor if other than Primary Doctor</b>
Blood Thinning Medicine <input type="checkbox"/> Plavix <input type="checkbox"/> Coumadin		
Antibiotics – type?		
High Blood Pressure Meds		
Other:		
Other:		
Other:		
Other:		
Other:		

<b>Non-Prescription/Herbal</b>	<b>Dose/Frequency</b>	<b>Prescribing Doctor if other than Primary Doctor</b>
Advil/Motrin/Ibuprofen		
Aleve/Naprosyn		
Aspirin		
Multi-Vitamin		
Vitamin E		
Herbal Supplements		
Other:		
Other:		
Other:		
Other:		

Do you have any **ALLERGIES** to medications?    No    Yes: list and describe reaction \_\_\_\_\_  
 \_\_\_\_\_

**What Pharmacy do you use?** \_\_\_\_\_

**REVIEW OF SYMPTOMS**

Please check off any of these symptoms that apply to you. Please circle any symptoms that you are currently experiencing.

- 1. **General:**             N/A     Chills     Fatigue     Weight loss     Weight gain     Daytime sleepiness
- 2. **Neuro:**             N/A     Headache     Weakness     Passing out     Numbness, tingling     Stroke
- 3. **Eyes:**             N/A     Eye pain/pressure     Vision changes
- 4. **ENT:**             N/A     Hearing loss     Lightheadedness     Sinus/Nasal congestion     Sleep apnea
- 5. **Respiratory:**     N/A     Cough     Coughing blood     Wheezing     Shortness of breath
- 6. **Cardiac:**         N/A     Chest pain     Palpitations     Awaken short of breath     Ankle swelling
- 7. **Gastro/Intestinal:**  N/A     Heartburn     Nausea/Vomiting     Difficulty swallowing     Irritable bowel
- 8. **Genito/Urinary:**  N/A     Frequent urination     Painful urination     Menopause     Prostate problems
- 9. **Allergy:**         N/A     Environmental allergy     Sneezing fits
- 10. **Heme/Lymph:**     N/A     Swollen glands     Sweating at night     Bleeding problems     Easy bruising
- 11. **Endocrine:**     N/A     Feel warmer than others     Feel cooler than others
- 12. **Musculoskeletal:**  N/A     Muscle aches     Joint pain     Joint swelling     Broken bones     Joint surgery     Ligament laxity
- 13. **Skin:**             N/A     Rash     Hives     Itching     Hair symptoms     Skin changes
- 14. **Psych:**         N/A     Depression     Anxiety     Panic
- 15. To help keep our medical records complete, please provide your **current height & weight:** \_\_\_\_ Feet \_\_\_\_ Inches \_\_\_\_ Lbs.

Please give a short explanation for anything checked off in the Review of Systems above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

Marital Status:     Single             Married             Partner             Separated             Divorced             Widowed

Do you live alone?    No     Yes

Are you the primary care taker for anyone other than yourself?

No     Child(ren)    Adult Child    Disabled Spouse    Parent    Other: \_\_\_\_\_

If applicable, who assists you in medical decision making?     N/A    \_\_\_\_\_

Do you have children?     No     Yes – How old are they? \_\_\_\_\_

Do you exercise?     Never     Rarely     Daily/Weekly     Monthly    What type of exercise? \_\_\_\_\_

What sporting activities/hobbies do you engage in? \_\_\_\_\_

Do you smoke?     No     Yes – Packs per day? \_\_\_\_\_    Pipes or Cigars per day? \_\_\_\_\_    **If you stopped – how long ago?** \_\_\_\_\_

Do you use alcohol?     No     Yes     Social

Do you have a history of substance abuse?     No     Yes – Describe: \_\_\_\_\_

Do you currently use a cane, walker, or wheelchair?    No     Yes – Describe use: \_\_\_\_\_

 <b>PATIENT'S SIGNATURE:</b> _____	<b>DATE:</b> _____
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Name of the person who completed this form if not the patient: \_\_\_\_\_ Relationship: \_\_\_\_\_

For Office Use Only:

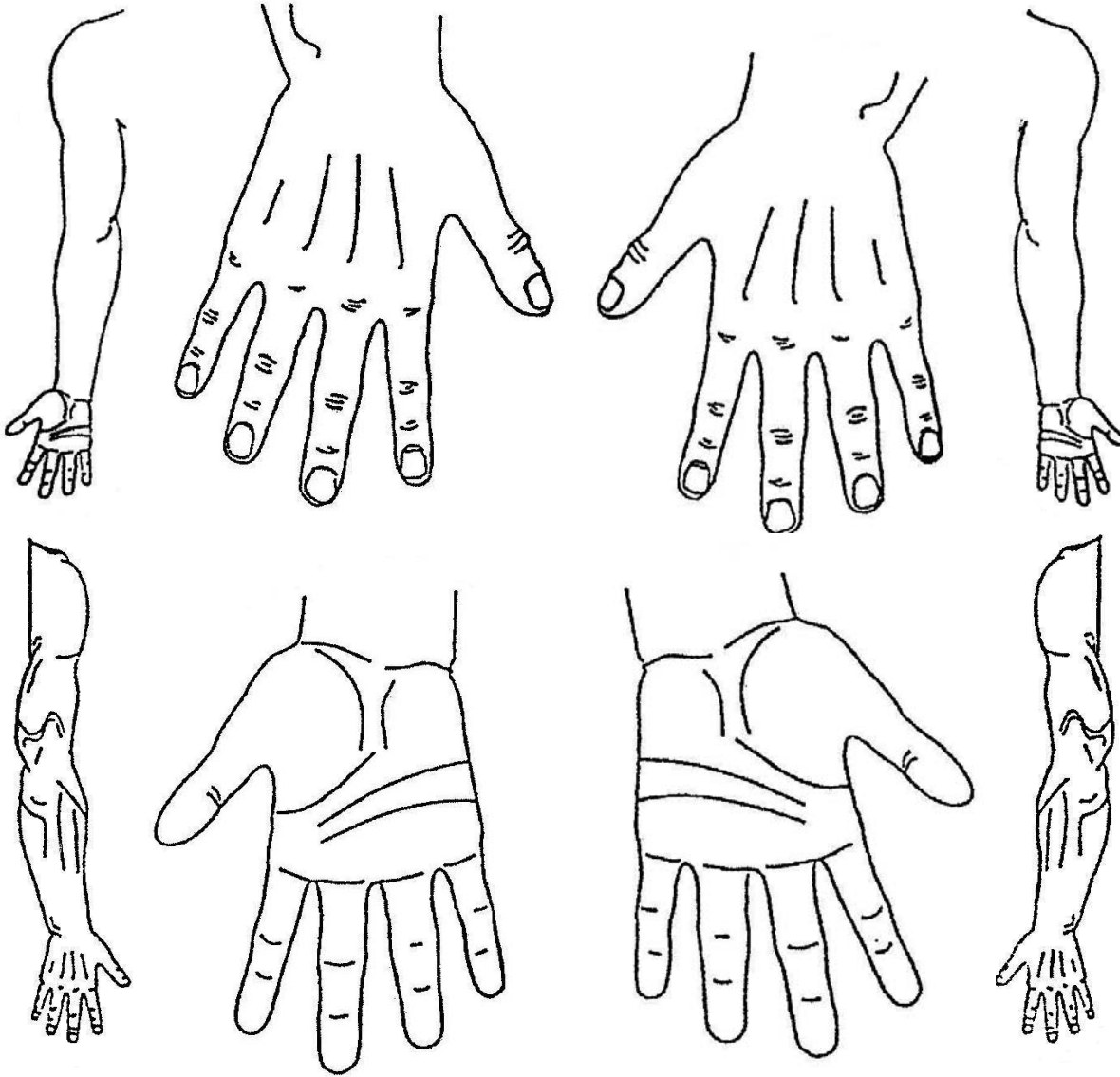
Reviewed by: \_\_\_\_\_ MD            Date: \_\_\_\_\_

**Respirations:** \_\_\_\_\_ Normal    \_\_\_\_\_ Abnormal (**Comment:** \_\_\_\_\_)

**Pulse:** \_\_\_\_\_ beats/min.

PHYSICIAN NOTES

DATE OF INJURY: \_\_\_\_\_



	<u>RIGHT</u>	<u>LEFT</u>
PHALENS		
Wr TINEL		
Thenar Atrophy		
ELBOW FT		
EIb TINEL		
1 <sup>st</sup> DI/ADQ/CLAW		
Wr Flex		
Wr Ext		
Wr RD		
WR UD		
GRIP		

X-ray

EMG's

Injection

Brace/Splint

Hand Therapy

Follow-up