Ronald BuczekII, DO
J. Taylor Lackey, MD
www.atx-handsurgery.com
11615 Angus Rd Suite 106 Austin, TX 78759
P: (512) 436-9986
F: (512) 436-8295

Hand Surgery New Patient Form

History

Visit Date (dd/mm/yy): ____/____/____ Name (Last, First): _____

Date of Birth (dd/mm/yy): ____/____/____ Age: _____ Sex: □ Male □ Female

Symptoms & Pain Assessment

1. Hand Dominance: □ Right □ Left □ Both
2. Upper extremity affected: □ Right □ Left □ Both

Which part of your arm is bothering you?

□ Shoulder □ Elbow □ Forearm □ Wrist □ Hand □ Thumb □ Index □ Middle □ Ring □ Small

3. Chief Complaint:
   _____
4. How long have you had these symptoms:
   _____
5. Describe your symptoms:
   _____
6. How did your symptoms start?
   _____
7. Was there an injury/event that caused your symptoms?
   □ Yes □ No – Date of Injury (dd/mm/yyyy): ____/____/____
   Please describe how your were injured:

_____

8. Any prior hand or upper extremity injury/pain before the event above?
   □ Yes □ No – What type?

_____

Previous Treatment & Evaluation

1. What tests have you had for this problem?

□ X-ray □ CT □ MRI □ EMG/NCS □ Blood tests □ Other:
_____

2. Have you had any of the following?
□ Surgery □ Steroid injections □ Physical therapy □ Splinting □ Pain medications
□ Other:
_____
__

Describe any surgery you underwent:
_____

Medical/Surgical History:

1. Please list other medical problems

□ High blood pressure	□ Arthritis	□ Diabetes	□ Heart disease
□ Stroke	□ Osteoporosis	□ High cholesterol	□ Cancer
□ Thyroid	□ Asthma	□ Stomach ulcer	□ Kidney stones
□ Blood clots in legs	□ Blood clots in lungs	□ Hepatitis C	□ AIDS/HIV
□ Other			

2. Have you every had hand or upper extremity surgery in the past?
□ No
□ Yes – Type of hand or upper extremity surgery

_____ Date: _____
_____

_____ Date: _____
_____

_____ Date: _____
_____

3. List any other surgeries

_____ Date: _____
_____

_____ Date: _____
_____

_____ Date: _____
_____

4. Do you have any implantable devices? □ No □ Yes Describe: _____

Hand Surgery New Patient Form

Family History

Does anyone in your family have the same problem?
□ No
□ Yes – Describe:
_____

Do any conditions run in your family?
_____

Social History

Marital status: □ Single □ Married □ Divorced □ Separated □ Widowed

Do you drink alcohol? □ Yes □ No – If yes, how much? _____

Do you smoke cigarettes? □ Yes □ No – If yes, how much? _____

Do you use recreational drugs? □ Yes □ No – If yes, which ones? _____

Are you currently working?

□ No
□ Yes – Describe:
_____

Allergies

Do you have any Allergies to Medications, Food, or Latex?

□ No
□ Yes – Describe:
_____

Medications

List any medications you take:

Medication	Dose	Route	Frequency	Time & Date Last Taken

Currently taking blood thinners? □ Yes □ No

Medication Name: _____

Are you currently taking a compound semaglutide injection? □ Yes □ No

Are you on Ozempic, Mounjaro, Wegovy, Trizepitide, Zepbound, Trulicity? □ Yes □ No

Pharmacy

Preferred Pharmacy Name:

_____

Pharmacy Address:

_____

Pharmacy Phone Number:

_____

Primary Care Physician

PCP Name:

_____

Practice Name:

_____

Street Address:

_____

City/State/ZIP:

_____