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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: _____

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Medical/Surgical History:

1. Please list other medical problems

□ Hypertension	□ 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 ever had hand or upper extremity surgery in the past?
   □ No
   □ Yes – Type of hand or upper extremity surgery

   _____ Date: _____

   _____ Date: _____

3. List any other surgeries

   _____ Date: _____

   _____ Date: _____

   _____ Date: _____

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

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:
_____

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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: _____