

**HAND SURGICAL ASSOCIATES**

Have you ever been diagnosed with the following?

YES NO

- Osteoporosis
- Arthritis
- Rheumatoid Arthritis
- Gout
- Diabetes
- Thyroid problems
- Heart disease
- High blood pressure
- Asthma
- Chronic lung disease
- Gastric reflux disease
- Stomach ulcers
- Bleeding disorders
- Phlebitis
- Epilepsy
- Anxiety
- Hepatitis
- Cancer – If yes, what type? \_\_\_\_\_

Have you had any significant problems in the past with the following?

YES NO

- Fevers/chills
- Chest pain
- Blood Clots
- Wheezing
- Heartburn
- Kidney stones
- Shingles
- Easy bleeding
- Seizures
- Tremor
- Depression

Do you have a family history of (circle and state which relative):

Relative(s) with problem

Osteoporosis \_\_\_\_\_  
Dupuytren's Disease \_\_\_\_\_

List all your current medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you take any of the following?

YES NO

- Coumadin
- Daily Aspirin
- Plavix
- Vitamin E

List any allergies to medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any of the following?

YES NO

- Penicillin
- Sulfa
- Latex

List all you prior surgeries: \_\_\_\_\_

Quantify these social activities:

Smoking: Never      ½ pack/day      1 pack/day      >1 pack/day

Alcohol: Never      Rare      Occasional      Moderate      Daily

What is your height? \_\_\_\_\_ What is your weight? \_\_\_\_\_

Your primary care doctor? \_\_\_\_\_ Who referred you for this visit? \_\_\_\_\_

Your age: \_\_\_\_\_ Right or left handed? \_\_\_\_\_ Male or Female? \_\_\_\_\_

Your occupation: \_\_\_\_\_

<u>Right / Left</u>	
Shoulder	R / L
Upper Arm	R / L
Elbow	R / L
Forearm	R / L
Wrist	R / L
Hand	R / L
Thumb	R / L
Fingers	R / L

Circle the area (s) of the upper extremity is the doctor to examine today?

Please note:

- Circle the basic areas. We will review the details during your examination.
- Due to time and insurance restrictions, each exam is limited to 2 body areas or, if you need a referral, to the area requested in your referral.

Is the reason for your visit related to an injury (such as a fall, cut, accident, or workman's compensation problem)? \_\_\_\_\_

If yes, what was the date of the injury? \_\_\_\_\_

Briefly, describe the injury: \_\_\_\_\_

\_\_\_\_\_

Did it occur at work? \_\_\_\_\_

Did it occur related to a car or car accident? \_\_\_\_\_

Were you treated for the injury? \_\_\_\_\_

If yes, where? \_\_\_\_\_

What are your symptoms? \_\_\_\_\_

When did the symptoms start? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Briefly describe the symptoms: \_\_\_\_\_

\_\_\_\_\_

Has the condition been treated so far with:

Anti-inflammatory meds? \_\_\_\_\_

Splint? \_\_\_\_\_

Therapy? \_\_\_\_\_

Injections? \_\_\_\_\_

Other? \_\_\_\_\_

Have any tests been done? \_\_\_\_\_

What if any. Diagnosis has been given for your condition? \_\_\_\_\_

**( Space for staff use only)**

Splinted?                      Reduction?

Skin?                              Sutured?

Tetanus?                      Abx?

Xrays & Dates?

N/T?

Prior?

Sx?

**( Space for staff use only)**

N/T?

Distribution?

Night sx?

Pain or N/T?

Prior?

Tests & Dates?

Patient accompanied by (relationship):

# **HAND SURGICAL ASSOCIATES**

**SIGNATURE ON FILE:** In order to submit a claim for payment to us for services covered under you policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize Orthopaedic Specialist, P.C. to release information Necessary to file a claim with my insurance company. I also authorize Orthopaedic Specialist, P.C. to submit a claim to my insurance carrier Or its intermediaries for all covered services rendered and direct my insurance Carrier or its intermediaries to issue payment directly to Orthopaedic Specialist, P.C. or the individual physician indicated on the insurance claim.

I understand that I am financially responsible for any balance not covered by My insurance carrier.

I hereby consent to and authorize the performance of medical treatment and/or Procedures by the physicians and others ( nurses, x-ray technologist, and Therapist ) of Orthopaedic Specialist P.C.

\* Medicare Patients \* I request that payment of authorized Medicare benefits Be made either to me or on my behalf to Orthopaedic Specialist, P.C. for Any services furnished to me by Orthopaedic Specialist, P.C. I authorize Any holder of medical information about me to release to Health Care Financing Administrations and its agents any information needed to determine These benefits payable for related service. I authorize any holder of Medicare Information about me to release to my Medicare Supplemental Insurance Carrier any information needed to determine their benefits payable for related Services.

A copy of this signature is as valid as the original.

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**Signature ( Patient or legal Guardian )**

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**Date**