Hand Surgery Specialists of Nevada

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HISTORY FORM

Today's Date: _____

Patient's Name: _____ Age: _____

Are you **RIGHT** or **LEFT** handed? (Circle One) Height: _____ Weight: _____

Occupation: _____

Employer: _____ Work Phone: _____

Referred By: _____ Phone Number: _____

Area of body you are being seen for: _____ Date of Injury: _____

Describe how your problem started:

_____

_____

_____

Circle appropriate responses or add other if not listed:

Past Medical History:

Anxiety	Heart Disease
Arthritis	Hypertension
Asthma/COPD	Kidney Disease
Bursitis	Neck Injury
Cancer	Osteoporosis
Carpal Tunnel	Rheumatoid Arthritis
Cubital Tunnel	Scleroderma
Depression	Sleep Apnea
Diabetes	Stroke
Gastritis//Ulcer	Thyroid Disease
Glaucoma	Tendinitis
Heart Attack	Recent Weight Change (≥ 15 #)

Other: _____

Past Surgical History: (Please circle or write)

Angioplasty	Hysterectomy
Appendectomy	Joint Replacement
Arthroscopy	Laparoscopy
Carpal Tunnel Rel.	Spine Surgery
C-section	Oral Surgery
Carotid Surgery	Prostate Surgery
Cosmetic	Tonsillectomy
Cubital Tunnel rel.	Trigger Finger Release
Foot Surgery	Tubal Ligation
Gall Bladder	_____
Heart Bypass	_____
Hernia Repair	_____
Fracture Care	_____

Current Medications: (i.e. Aspirin, Coumadin, Plavix)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Drug Allergies? (i.e. Penicillin, Sulfas, Iodine)

_____

Social History:

Tobacco: _____ pk(s)/day
Alcohol: _____
Hobbies/Interests: (ie, golf, knitting)

Work Status:

Full Duty	Full-time
Light Duty	Part-time

Work Restrictions: _____

History of Anesthetic Problems/Complications? (ie, nausea)

_____
_____