

MEDICAL HISTORY FORM

PLEASE COMPLETE ALL SECTIONS ON THIS FORM. WRITE "NONE" OR "N/A" IF SOMETHING IS NOT APPLICABLE.

PATIENT'S NAME: _____ TODAY'S DATE: _____

DOMINANT HAND: RIGHT LEFT HEIGHT: _____ (inches) WEIGHT: _____ (lbs)

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____ TELEPHONE NUMBER: _____ LOCATION/CITY: _____

LIST ALL MEDICAL CONDITIONS DIAGNOSED BY A PHYSICIAN (INCLUDING THOSE YOU TAKE OR DO NOT TAKE MEDICATION FOR):
*****YOU MAY ATTACH YOUR OWN LIST TO THIS FORM (AND WRITE "SEE ATTACHED"). FOR ADDITIONAL SPACE, USE ANOTHER SHEET.**

MEDICAL CONDITIONS:

LIST ALL MEDICATIONS YOU ARE TAKING (INCLUDING VITAMINS/SUPPLEMENT, ETC.)
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MEDICATION NAME:	FOR WHICH CONDITION?	DOSE:	PRESCRIBING PHYSICIAN:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES: PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING AND LIST ALL YOU MAY HAVE (OR SUSPECT YOU MAY HAVE):

MEDICATIONS? NO YES _____

ANESTHETICS? NO YES _____

INJECTIONS? NO YES _____

LATEX RUBBER? NO YES _____

OTHER: _____

LIST ALL PAST SURGERIES: _____ **DATE PERFORMED:** _____ **SURGEON:** _____ **LOCATION/CITY:** _____
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ALL PAST "HAND AND WRIST" INJURIES: _____ **DATE OF INJURY:** _____ **TREATING PHYSICIAN:** _____ **LOCATION/CITY:** _____
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY FORM (CONT.)

DO YOU SMOKE? NO YES (HOW OFTEN: _____)

CHECK APPLICABLE: TOBACCO CIGARETTES CANNABIS VAPE

LIST YOUR HOBBIES/SPORTS: _____

OCCUPATION (IF APPLICABLE): _____

REVIEW OF SYSTEMS: CHECK ALL THAT APPLY

GENERAL: Fatigue Unexpected Weight Loss

EYES: Recent Visual Changes Other:

EAR/NOSE/THROAT: Sore Throat Nasal Drainage or Congestion Ear Pain Other:

LUNGS: Cough Sputum Shortness of Breath Other:

HEART: Chest Pain Palpitations Other:

STOMACH/INTESTINES: Abdominal Pain Nausea/Vomiting Incontinence Other:

URINARY: Problems Urinating Abnormal Discharge Incontinence Other:

HEMATOLOGY: Easy Bruising Clotting Disorder Anemia Other:

SKIN: Skin Rash Other:

PSYCHIATRIC: Depression Anxiety Other:

IMMUNE SYSTEM: Frequent Infections Other:

**BONES/JOINTS:
(OTHER THAN HAND/WRIST)** Joint Aches Back Pain Other:

LIST ADDITIONAL MEDICAL INFORMATION WE SHOULD BE AWARE OF:

PATIENT (OR LEGAL GUARDIAN) SIGNATURE: _____

DATE: _____