Carolina Hand Medical Questionnaire

Height: _____

Weight: _____

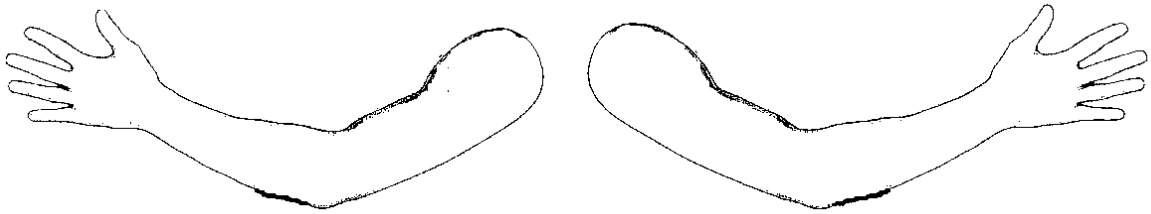
Date: _____

Name: _____

Date of Birth: ____ / ____ / ____ **Age:** _____

Reason for Today's Visit: _____

Please mark on the diagram below where your pain/injury is occurring:



Please rate your pain on a scale of 1-10. 1 being barely noticeable and 10 being you need to go to the emergency room. _____

Date of illness or injury: ____ / ____ / ____

Were you hurt on the job? _____ **If so, how?** _____

Please describe what your current duties are at work if applicable: _____

Are you represented by an attorney? _____ **If so, whom?** _____

Primary Care Physician (name and phone): _____

DRUG ALLERGIES: (list any problems you have with medications, shellfish, soap, latex, etc., and state your reaction.)

Drug	Reaction

☐ No Known Drug Allergies

CURRENT MEDICATIONS: (include vitamins, birth control medication, non-prescription)

Drug Name	Dose	How Often

If x-rays are needed, is there a possibility you may be pregnant? ☐ **Yes** ☐ **No**

PAST MEDICAL HISTORY

☐ Anxiety	☐ Depression	☐ Arthritis	☐ Asthma	☐ Emphysema
☐ Blood Disorders	☐ Cancer	☐ Diabetes	☐ Fibromyalgia	☐ HIV/AIDS
☐ Hypertension	☐ Kidney Disease	☐ Liver Disease	☐ Mental Illness	☐ Stomach Ulcer
☐ Thyroid Disease	☐ Drug Abuse	☐ Alcohol Abuse	☐ Heart Disease	☐ No History

PREVIOUS SURGERIES / TREATMENTS — YEAR

_____ _____

_____ _____

_____ _____

_____ _____

☐ No Surgical History

FAMILY HISTORY: (indicate which blood relative)

☐ Arthritis _____

☐ Cancer _____

☐ Diabetes _____

☐ Heart Problems _____

☐ High Blood Pressure _____

☐ Anesthesia Problems _____

☐ History Unknown ☐ No Family History

SOCIAL HISTORY:

Are you: ☐ Right Handed ☐ Left Handed ☐ Right and Left Handed

☐ Male ☐ Female

Employer: _____ Job Title: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Children? ☐ Yes ☐ No

Current Smoker? ☐ Yes ☐ No ☐ Former Smoker

Type of Tobacco _____ Number of Packs per Day _____

When did you stop? _____ For How Many Years _____

Do you drink Alcohol? ☐ Yes ☐ No Type _____ How many _____

How Often? ☐ Never ☐ Rarely ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially

Do You Exercise? ☐ Yes ☐ No

How often? ☐ Daily ☐ Occasionally ☐ Once a Week ☐ 2-5 times a week ☐ Never

Type of Exercise: _____

Hobbies or Interests: _____

REVIEW OF SYSTEMS (ROS): Check any of the following you have had in the last six months:

☐ Bleeding problems	☐ Heartburn	☐ Urinary frequency
☐ Chest pain	☐ Joint or muscle problems	☐ Weight gain
☐ Depression/Anxiety	☐ Rash or skin problems	☐ Headaches
☐ Environmental allergies	☐ Shortness of breath	☐ Unusual fatigue
☐ Eye/Vision problems	☐ Ear, nose, mouth or throat problems	
☐ No Known Medical Problems		

Patient Signature: _____ **Date:** _____ **Time:** _____

Reviewed by: _____ **Date:** _____ **Time:** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)