

Name:
DOB:
Chart:
Age:
Date:

HAND TO SHOULDER SPECIALISTS OF WISCONSIN
PATIENT HISTORY INFORMATION

Patient Name _____ Date of Birth _____

Occupation _____ Sex: _____ Marital Status _____

Are you right or left handed? (please circle one)

What are you seeing the doctor for?

Injury / complaint: _____

Current Symptoms/Complaints: _____

Date of Injury or Onset of Symptoms: _____

Please list all current medications, including non-prescription drugs:

Do you use medications to manage your pain? _____ Yes _____ No

If yes, what medication? _____ Who prescribed this? _____

Please list all previous surgeries, serious illnesses and/or injuries (even those not related to your hand problem):

Please list all allergies, including food, drugs, latex, tape, etc:

Have you ever had problems with anesthesia? _____ Yes _____ No

If yes, please explain: _____

Do you use, or have you ever used tobacco? _____ Yes _____ No Amount per day _____

Do you drink alcohol? _____ Yes _____ No Amount per day _____

Do you consume caffeine? _____ Yes _____ No Amount per day _____

Do you use, or have you ever used, drugs for recreational or non-prescribed purpose?

_____ Yes _____ No What type _____ How much _____ Last used _____

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Do you currently have, or have you ever had, any of the following: (Please circle Yes or No)

Allergies	Yes	No	_____
Cancer	Yes	No	_____
Are you currently pregnant?	Yes	No	_____
Are you currently breast feeding?	Yes	No	_____
RESPIRATORY:			
Respiratory/Breathing Problems	Yes	No	_____
Asthma/Shortness of Breath	Yes	No	_____
Tuberculosis/Pneumonia	Yes	No	_____
CARDIOVASCULAR:			
Heart Disease	Yes	No	_____
Heart Attack	Yes	No	_____
High Blood Pressure	Yes	No	_____
Chest Pain	Yes	No	_____
HEMATOLOGICAL:			
Blood Disorders/Anemia/			
Blood Clots/Sickle Cell	Yes	No	_____
GI:			
Hepatitis/HIV	Yes	No	_____
Stomach Disorders/Ulcers	Yes	No	_____
Liver Disease	Yes	No	_____
GU:			
Urinary/Kidney Disorders/Frequency	Yes	No	_____
Genital Problems/Disease	Yes	No	_____
NEUROLOGICAL:			
Nerve Disorders	Yes	No	_____
Mental Health Problems	Yes	No	_____
Weakness/Numbness/Tremors	Yes	No	_____
Headaches	Yes	No	_____
Seizures	Yes	No	_____
Stroke	Yes	No	_____
ENDOCRINE:			
Diabetes	Yes	No	_____
Thyroid Disease	Yes	No	_____
INTEGUMENTARY:			
Skin Disease:	Yes	No	_____
MUSCULOSKELETAL:			
Muscle/Bone Problems	Yes	No	_____
Osteoporosis	Yes	No	_____
Osteoarthritis or Rheumatoid Arthritis	Yes	No	_____
ENT:			
Ear/Nose/Throat/Eye Problems	Yes	No	_____

Do any of your blood relatives have a history of any of the above? No ___ Yes ___

Please explain: _____

Patient Signature	Date	Reviewed By	Date
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