PATIENT MEDICAL HISTORY

NORTH TEXAS HAND SURGERY ASSOCIATES, LTD., L.L.P.

PATIENT NAME: _____ DATE: _____

TYPE OF WORK: _____

DO YOU SMOKE? Y N ARE YOU: RIGHT HANDED ☐ LEFT HANDED ☐

PERSONAL HISTORY - ONLY INCLUDE INFORMATION ABOUT YOURSELF

Have **YOU** had any previous problems with the following?

A. Head	Y	N	***G.*** Heart	Y	N	***M.*** Abdomen	Y	N	***S.*** Muscles	Y	N
B. Eyes	Y	N	***H.*** Lungs	Y	N	***N.*** Kidneys	Y	N	***T.*** Skin	Y	N
C. Ears	Y	N	***I.*** Stomach	Y	N	***O.*** Bladder	Y	N	***U.*** Nervous System	Y	N
D. Nose	Y	N	***J.*** Liver	Y	N	***P.*** OB/GYN	Y	N	***V.*** Psychiatric	Y	N
E. Throat	Y	N	***K.*** Pancreas	Y	N	***Q.*** Bones	Y	N			
F. Chest	Y	N	***L.*** Intestine	Y	N	***R.*** Joints	Y	N			

Briefly explain any "YES" items:

_____

_____

_____

_____

Have you ever had any previous problems with your arms or hands? Y N
Explain _____

Have you ever been admitted to a hospital? Y N
Explain _____

Have you ever had surgery? Y N
Explain _____

Do you take any medications regularly? Y N
Please list _____

Do you have any ALLERGIC or ADVERSE reactions to any Medications? Y N
List Medication & Reaction _____

Have you ever had any problems with prolonged bleeding? Y N
Explain _____

FAMILY HISTORY - DO NOT INCLUDE INFORMATION ABOUT YOURSELF

Has any **BLOOD RELATIVE** (siblings, parents, grandparents, etc.) ever had?

Diabetes	Y	N	Explain	_____
Cancer	Y	N	Explain	_____
Heart Disease/Problems	Y	N	Explain	_____
Tuberculosis	Y	N	Explain	_____
Bone/Joint Problems	Y	N	Explain	_____