Michigan Hand and Wrist, P.C.

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New Patient History Form

Patient Name: _____ Date: _____

Date of Birth: _____

This questionnaire includes information about your medical history and other information that is not available from lab tests, x-rays or any source other than you. Please try to answer each question as carefully as you can. Thank you.

What problems bring you to see the Doctor? _____

When did the problem begin? _____

If an injury, how did it occur? _____

Is this a **LEFT** or **RIGHT** sided injury? (circle one) Is this injury WORK or AUTO related? **YES** / **NO** (circle one)

If you missed any work due to this problem, what dates? Beginning: _____ Ending: _____

Who referred you? _____ If referral is a doctor, phone # _____

Is referral from Yellow Pages? **YES** / **NO** **(**circle one) Is this regarding a 2nd opinion? **YES** / **NO** (circle one)

Who is your Family or Primary Care physician? _____ phone# _____

Height: _____ Weight: _____ Are you Right Handed or Left Handed?

1. Please write below the names of all the drugs or medications you are currently taking for any condition. Include aspirin, birth control pills, vitamins and herbal medicines and any non-prescription medicines.

	Name of Drug/Medicine	Dose	How many per day/week
1.			
2.			
3.			
4.			
5.			

2. Please list all medications that you are allergic to and name the type of reaction you experienced. (i.e. rash, shortness of breath)

Name of Medication	Reaction	Name of Medication	Reaction
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

3. Please circle "YES" or "NO" to indicate if you have had any of the conditions listed below. If you answer "YES", please indicate the age or year the problem began.

Have you ever had……?			**AGE**	**YEAR**
High Blood Pressure	NO	YES	_____	_____
Diabetes	NO	YES	_____	_____
Heart Attack	NO	YES	_____	_____
Other heart disease	NO	YES	_____	_____
Stomach ulcer	NO	YES	_____	_____
Other gastrointestinal problems	NO	YES	_____	_____
Asthma	NO	YES	_____	_____
Bronchitis or emphysema	NO	YES	_____	_____
Other lung problem	NO	YES	_____	_____
Thyroid Problem	NO	YES	_____	_____
Cancer	NO	YES	_____	_____
Stroke	NO	YES	_____	_____
Anemia	NO	YES	_____	_____
Other Hematological problems	NO	YES	_____	_____
Kidney Problems	NO	YES	_____	_____
Gynecological or prostate problems	NO	YES	_____	_____
Psoriasis	NO	YES	_____	_____
Blood Clots	NO	YES	_____	_____
Rheumatoid arthritis	NO	YES	_____	_____
Osteoarthritis	NO	YES	_____	_____
Lupus	NO	YES	_____	_____
Back or spine problems	NO	YES	_____	_____
Fibromyalgia	NO	YES	_____	_____
Osteoporosis	NO	YES	_____	_____
Broken bones after age 50	NO	YES	_____	_____
Cataracts	NO	YES	_____	_____
Glaucoma	NO	YES	_____	_____
Parkinson's Disease	NO	YES	_____	_____
Depression	NO	YES	_____	_____
Mental Illness	NO	YES	_____	_____
Alcoholism	NO	YES	_____	_____
Eye Inflammation	NO	YES	_____	_____
Other _____	NO	YES	_____	_____

4. Please list below all operations you have had. Please check here if *NONE*: _____

	Operation	Year	Hospital, City, State
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

5. Please list below all major illnesses or admissions to a hospital, other than surgery. Please check here if *NONE*: _____

	Illness/reason for hospitalization	Year	Hospital, City, State
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

6. Family medical history:

	IF LIVING:		IF DECEASED:	
	Age	Any major medical conditions	Age at death	Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Son(s)	_____	_____	_____	_____
Daughter(s)	____	_____	_____	_____

7. Please check if you have used any of the following:

Tobacco _____ Alcohol _____ Drugs not sold in stores _____
Packs per week _____ Drinks per week _____ Use per week _____

8. The following questions are about your social situation:

Marital Status (circle one) Single Married Divorced Widowed Separated

What is your current occupation? _____

If not currently working, what was your prior occupation: _____

Please circle all that apply: *At this time, are you…..?*

Working full time	Retired	Working part time	Student
Homemaker	Disabled	Other (describe) _____	

How many other people live at home with you? _____
Please check all that live with you;

_____Spouse/partner _____Parent(s) _____Sons or daughters
_____I live alone _____Others (describe) _____

How many years of school have you completed:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

9. Please check if you have experienced any of the following *over the last month*:

_____Fever	_____Shortness of breath	_____Muscle weakness
_____Weight gain	_____Wheezing	_____Numbness or tingling of arms/legs
_____Headaches	_____Heart pounding	_____Joint stiffness in the morning
_____Unusual fatigue	_____Trouble swallowing	_____Swelling of hands
_____Swollen Glands	_____Heartburn of stomach gas	_____Swelling of ankles
_____Loss of appetite	_____Stomach pains or cramps	_____Swelling in other joints
_____Skin rash	_____Nausea	_____Joint pain
_____Back pain	_____Vomiting	_____Rash from sun exposure
_____Constipation	_____Neck pain	_____Unusual bruising or bleeding
_____Loss of hair	_____Diarrhea	_____Fingers turn white or blue when cold
_____Dry eyes	_____Dark or bloody stools	_____Depression
_____Other eye problems	_____Problems with urination	_____Anxiety
_____Problems with hearing	_____Gynecological (female) problems	_____Problems with thinking
_____Sores in the mouth	_____Dizziness	_____Problems with memory
_____Dry mouth	_____Losing your balance	_____Problems with sleeping
_____Lump in throat	_____Muscle pain, aches or cramps	_____Other: _____

10. Please check if this questionnaire has been completed:

_____ Entirely by you _____With help from: _____

Patient Signature: _____

I have personally reviewed and discussed this questionnaire with the patient.

_____ _____
Physicians Signature Date