The Hand & Upper Extremity Center of San Antonio

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PATIENT INFORMATION

Patient Name: DOB: Age: Sex: F M

Phone Cell: SSN xxx-xx Marital Status:

Address: City: State: Zip:

Employer Name: Phone:

Emergency Contact: Phone:

E-mail: Preferred Language:

Ethnicity: Hispanic or Latino Other : Student Status: Full Time Part Time

PRIMARY INSURANCE INFORMATION

Primary Insurance Name:

Name of Insured: Phone: DOB:

SSN xxx-xx Insurance ID Number: Group Number:

Address: City: State: Zip:

Relationship to Patient:

WORK RELATED INFORMATION (FOR WORKER'S COMPENSATION INJURIES ONLY)

Employer: Phone: Date of Injury:

Address: City: State: Zip:

REVIEWED BY DATE PATIENT#/ DOCTOR #

(PLEASE PRINT CLEARLY/ BLACK INK ONLY)

TODAY'S DATE:

Referring or Primary Physician:

Location: Office Number:

What did they do for you:

Patient Name: **Age:** **Sex:** F M

For Minor Children: Mother's Name: Father's Name:

Are you: RIGHT-Handed LEFT- Handed Use BOTH equally? Circle One

What is your job or profession:

Chief Complaint- Please briefly describe in your own words the reason for your visit

HISTORY OF PRESENT ILLNESS

1. When did this problem begin (date of injury or onset):

2. If you had an injury, how & where did it happen? What were you doing?

3. Problem is the result of (Circle one):
Car accident Work Accident Sport Other

4. Side of problem or injury (Circle one): Right Left Both sides

5. Location of Problem or Injury (Circle all that apply)
Shoulder Elbow Forearm Wrist Hand Thumb Finger Other:

6. How would you describe your symptoms (Circle all that Apply)
Pain Numbness Tingling Clicking Popping Locking Stiffness

7. Quality of pain: Sharp Shooting Stabbing Electric Dull Throbbing "Achy" Other

8. Severity of pain (0= no pain, 10= most intense pain you have ever experienced) Circle one
0 1 2 3 4 5 6 7 8 9 10

9. Duration (how long have you had symptoms)

10. Frequency (how often do you experience your symptoms?)

Please answer both questions by circling what best describes you:

a. " I experience these symptoms: Rarely Sometimes Off & On Often Constantly "

b. " My symptoms occur mostly: In the morning During the day At night "

11. What have you tried for it so far? (Circle all that apply)
Nothing Rest Stretching Medication Cream Splint or Brace Heat Ice Steroid injections Surgery

12. Aggravating Factors (What makes it worse?)

13. Alleviating Factor (What makes it better?)

14. Are you currently being cared for by a pain management physician? Yes No

Name of Physician:

Tobacco use? (Required for all patients 12 years and older) Never Smoke

Types (Circle One): Cigarettes Pipe Cigars Snuff Chew Vape

Yes, I am a current tobacco user. Amount & Frequency:

How many years:

No, but I used to. Amount & Frequency:

Total years of tobacco use: Quit date:

Alcohol Use?

Never used alcohol

What kind? Wine Beer Liquor (Circle all that apply)

Yes, Rarely (1/month) Occasionally (1-4/ month) Daily

No, Used to but stopped on (date)

Use of controlled or illegal substances? Yes No

If so, which drugs do/did you use?

How often do you exercise?

Never Rarely (<1/month) Occasionally (1-4/month) Frequently (3-5/week)

DEXA Scan/Bone Density (For Women older than 65yrs of age)

Yes, if so approximately when?

No

Fall Risk: (All Patients over 65yrs of age)

Have you had a fall in the past 2 years? Yes No

If so, when?

Do you have legal representation related to your problem?

Yes No

Do you have an advanced care plan?

Yes, and I have provided my advanced care plan to The Hand Center of San Antonio to keep in my medical record.

No, I do not have an advanced care plan, but I would like to designate the following as my surrogate decision maker if I am unable to make my own medical decisions for any reason:

Name: Relationship

Phone Number:

No, I do not have an advanced care plan and would not like to designate a surrogate decision maker now.

Allergies

Do you have any medication allergies? Yes No If so, please list:

Are you allergic to Latex? Yes No
Are you allergic to iodine? Yes No

Preferred Pharmacy: Location:

Phone Number:

List all current medications: (OR PROVIDE SEPERATE LIST)

MEDICATION	DOSE	TIMES PER DAY

Personal Medical History: Have you had or have any of the following conditions? (Check all that apply)

Asthma
Bleeding/clotting disorder
Cancer
Cardiovascular Disease
Congestive Heart Failure
COPD
Diabetes Type 1
Diabetes Type 2
DVT
GERD
Heart Attack

Heart Murmur
Heart Stent
Hepatitis
HIV
Hypertension
Kidney Disease
Hyperlipidemia
Osteoporosis
Pulmonary Embolism
Rheumatoid Arthritis
Seizures

Stroke
Thyroid Disorder

List any other medical conditions:

N/A

Past Surgical History: List all surgeries below or provide list (CIRCLE HERE IF NONE

Review of Systems - Have you had or are you currently having problems with any of the following:

Systems

General	Weight gain or loss	Fever	Glaucoma
Eye	Glasses/Contacts	Cataracts	Ringing in ears
Ear/Nose/Throat	Sinus Trouble	Hearing Loss	
Heart	Irregular heartbeat	Chest Pain	Persistent Cough
Lung	Shortness of breath	Difficulty breathing	
Stomach	Constipation	Heartburn	
Muscles	Pain	Fractures	
Urinary Tract	Bladder/Kidney infections	Prostate problems	Painful urinating
Skin	Masses	Non-healing wounds	
Neurology	Numbness and Tingling	Severe headaches	
Mental Health	Anxiety	Depression	
Endocrine	Increased Thirst	Thyroid disorder	
Blood/Lymph	Anemia	Swollen or enlarged lymph nodes	
Immunological	Hay fever		

Family Medical History: Check all that apply (Circle family member)

					List any other conditions:
Bleeding/Clotting disorder	Father	Mother	Brother	Sister	
Cancer	Father	Mother	Brother	Sister	
Cardiovascular Disease	Father	Mother	Brother	Sister	
Congestive Heart Failure	Father	Mother	Brother	Sister	
COPD	Father	Mother	Brother	Sister	
Diabetes	Father	Mother	Brother	Sister	
HIV	Father	Mother	Brother	Sister	
Hyperlipidemia	Father	Mother	Brother	Sister	
Hypertension	Father	Mother	Brother	Sister	
Kidney Disease	Father	Mother	Brother	Sister	
Osteoporosis	Father	Mother	Brother	Sister	
Rheumatoid Arthritis	Father	Mother	Brother	Sister	
Stroke	Father	Mother	Brother	Sister	N/A

I understand that any person who knowingly and with intent defrauds any insurance company or other persons. Files a statement or claim containing any materially false information or who conceals, for the purpose of misleading, information concerning any fact, commits a fraudulent act, which is a crime subject to criminal prosecution and civil penalties.

Signature of patient, parent or guardian (if minor) Date