Bloomfield
HAND SPECIALISTS

MEDICAL HISTORY

Today's Date: ____/____/____

PATIENT NAME (PLEASE PRINT)			BIRTH DATE			AGE	MALE	FEMALE
FIRST	LAST	M.I.	MM	DD	YYYY		☐	☐
PARENT/GUARDIAN NAME IF PATIENT IS A MINOR			HEIGHT			WEIGHT		
FIRST	LAST	M.I.						

ETHNICITY & RACE IS A FEDERAL REQUIREMENT MANDATED BY CMS-CENTERS FOR MEDICARE & MEDICAID SERVICES

ETHNICITY:
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO

RACE:
☐ AMERICAN INDIAN / ALASKAN NATIVE
☐ ASIAN
☐ BLACK/AFRICAN-AMERICAN
☐ NATIVE HAWIIAN OR PACIFIC ISLANDER
☐ WHITE

PREFERRED LANGUAGE: ☐ ENGLISH ☐ ESPAÑOL OTHER:

REFERRED BY:	PRIMARY CARE PHYSICIAN:	PREFERRED PHARMACY (PHONE):
NAME	NAME	PHARMACY NAME (###)-###-####

CHIEF COMPLAINT

Why are you seeing the doctor today?

Have you been to an Emergency Room or Urgent Care Center for this problem ? ☐ YES ☐ NO

If yes, which facility?

When did your symptoms start or injury occur?

What tests have been performed?
☐ Xray ☐ CT Scan ☐ MRI ☐ EMG ☐ Other:

What treatments have you tried:

Choose a number between 0 and 10 that best describes your pain:

No Pain	Mild		Moderate		Severe		Very Severe			Excruciating
0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Is your complaint work related? ☐ YES ☐ NO

Is this automobile related? ☐ YES ☐ NO

PAST MEDICAL HISTORY

☐ None
☐ Asthma
☐ Cancer
☐ HIV or AIDS
☐ Blood Clots
☐ Rheumatoid Arthritis
☐ Other:
☐ High Blood Pressure
☐ Sleep Apnea
☐ Diabetes
☐ Ulcer or Acid Reflux
☐ Bleeding Problems
☐ Autoimmune Disease
☐ Heart Disease
☐ Seizure Disorder
☐ Hepatitis
☐ Thyroid Problems
☐ Psoriasis
☐ Anxiety or Depression

PAST SURGERIES: (Please list all previous surgeries and approximate dates)

ANESTHETIC

Have you ever had anesthesia? ☐ YES ☐ NO

If yes, have you had any reaction to local or general anesthetic? ☐ Y ☐ N

If yes, Please describe:

MEDICATIONS

Please list all current medications and dosages if known. Remember to include over the counter medications, herbal supplements, and prescription medicines.

☐ None

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ALLERGIES	SOCIAL HISTORY:	
Please list all known allergies and the type of reaction: ☐ None	Occupation: ☐ Student/Name of School:	MARITAL: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed CHILDREN?: ☐ Yes ☐ No LIVE ALONE?: ☐ Yes ☐ No EXERCISE: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
	Do you smoke? ☐ Yes ☐ No ☐ Quit If yes, ___ packs per day for ___ years If quit, when did you quit? _____	Do you drink alcohol? ☐ Yes ☐ No If yes, average drinks per week _____

FAMILY HISTORY: (PLEASE CHECK ALL THAT HAVE SIGNIFICANCE IN YOUR FAMILY'S HISTORY, NOT YOUR OWN HISTORY)

NONE: ☐	Arthritis	Diabetes	Heart disease	Stroke	Cancer	Other
FATHER	☐	☐	☐	☐	☐	☐
MOTHER	☐	☐	☐	☐	☐	☐
SIBLINGS	☐	☐	☐	☐	☐	☐

List family history of orthopedic problems:

REVIEW OF SYSTEMS: Check all symptoms that apply to you from each of the 14 categories.

CONSTITUTIONAL	☐ None	☐ Night sweats	☐ Fever/chills	☐ Unexpected weight gain ___lbs in the last year?	☐ Unexpected weight loss ___lbs in the last year?
EYES	☐ None	☐ Visual changes	☐ Glasses or Contacts		
EARS, NOSE, THROAT	☐ None	☐ Hearing problems	☐ Sore throat	☐ Cold	☐ Sinus allergies
CARDIOVASCULAR	☐ None	☐ Chest Pain	☐ Palpitations	☐ Leg swelling	☐ Calf cramps with walking
RESPIRATORY	☐ None	☐ Shortness of breath	☐ Wheezing	☐ Frequent cough	☐ Coughing up blood
GASTROINTESTINAL	☐ None	☐ Ulcer	☐ Bowel/bladder control	☐ Diarrhea	☐ Vomiting
GENITOURINARY	☐ None	☐ Incontinence	☐ Burning while urinating	☐ Blood in urine	☐ Kidney stones
MUSCULOSKELETAL	☐ None	☐ Back ache	☐ Joint stiffness	☐ Joint swelling	☐ Joint pain
INTEGUMENTARY	☐ None	☐ Rash	☐ Hair problem	☐ Nail problem	
NEUROLOGICAL	☐ None	☐ Headaches	☐ Memory loss	☐ Fainting	☐ Tingling and numbness
PSYCHIATRIC	☐ None	☐ Depression	☐ Nervousness	☐ Personality change	☐ Previous psychiatric care
ENDOCRINE	☐ None	☐ Excessive urination	☐ Excessive thirst	☐ Intolerance to heat/cold	
HEMATOLOGIC/ LYMPHATIC	☐ None	☐ Abnormal bleeding	☐ Anemia		
ALLERGIC/IMMUNOLOGIC	☐ None	☐ Immunization problems	☐ Allergy shots		

THIS INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

Patient Name (Please Print)	Guardian Name (Please Print)
Patient Signature: Date	Guardian Signature: Date
Physician Signature Date	