



538 Oak Street
Cincinnati, OH 45219
Phone: 513-961-7740
Fax: 513-961-7742

Name: _____

Surgery: _____ wt _____ lbs.
ht _____ "

ALLERGIES KNOWN (please list) NKA
(drug and food) Latex
Type of Reaction

CURRENT MEDICATIONS:
(please list)

NAME	STRENGTH	TIMES/DAY	TIME OF LAST DOSE

IN THE PAST **6 MONTHS** I HAVE TAKEN Diet Pills _____
Steroids _____ Blood Thinners _____ Chemotherapy _____ Radiation Tx _____

PAST SURGERY (please circle)

Brain	Heart	Lung	Hand
Eye	Angioplasty	Orthopedic	Gyn
ENT	Stent	GU	Other
Teeth	Blood Vessels	Breast	
Thyroid	GI	Colonoscopy	

Comments:

PAST ANESTHETICS (please circle)

Local	General/sleep	Spinal	None
Axillary Block	Bier Block	Twilight/MAC	Epidural

HAVE NOW OR HISTORY OF?	YES	NO	MD OFFICE USE ONLY
Have you ever had an unusual or bad reaction to a local or general anesthetic?			<input type="checkbox"/> N/V
Has a blood relative ever had a bad reaction to a local or general anesthetic?			<input type="checkbox"/> N/V

HAVE NOW OR A HISTORY OF?	YES	NO
Heart Disease		
Chest Pain or Angina		
Heart Attack/M.I.		
Congestive Heart Failure		
Arrhythmia		
MVP/Valvular Heart Disease		
Pacemaker/Defibrillator		
High Blood Pressure		
Circulation/Blood Vessel Disease		
Normal Exercise Tolerance		
Respiratory (Lung) Disease		
A Cold, Presently		
Sleep Apnea		
COPD/Emphysema		
Asthma		
Diabetes I II		
Thyroid Problems ↑ ↓		
Kidney Disease		
Bleeding Problems/Blood Disease		
Anemia/Sickle Cell Disease		
Ulcers/Hiatal Hernia/GERD		
Jaundice/Hepatitis/Liver Disease		
Muscle Dystrophy/Weakness		
Convulsions/Epilepsy/Seizures		
Stroke/Polio/Paralysis/MS		
Glaucoma		
Cancer		
Other Illness		
Do you smoke? _____ packs/day		
Have you ever smoked?		
Do you drink alcohol?		
Recreational drug use?		
Ever addicted to drugs or alcohol?		
HIV/AIDS		
Dentures/Partial Plates		
Caps/Bridges/Bonded Teeth		
TMJ/Jaw Problems		
Pregnant/Missed a Period?		
Last Menstrual Period		

mo. _____ yr. _____

only ADL light house work
 one flight of stairs stopping

CPAP
 home O₂

x _____ yrs insulin

dialysis

x _____ yrs.
_____ quit
_____ per week
 cocaine

neg hcg
mo. _____ day _____

PATIENT'S/NURSE'S SIGNATURE: _____ DATE: _____

Hand Surgery Specialists, Inc.

Name: _____ Today's date: _____ Age: _____ Sex: M F

Occupation: _____ Weight: _____ Height: _____

Are you **right** or **left** handed or **ambidextrous**? (Circle one) Right Handed Left Handed Ambidextrous

Is your problem a result of an injury? Yes No (Circle one) Date of injury: _____

If your problem is a result of an injury or accident, did it occur at work? Yes No (Circle one)

If your injury occurred at work, have you filed a worker's compensation claim yet? Yes No (Circle one)

Have you contacted an attorney? Yes No (Circle one)

Are you working now? Yes No (Circle one) If not currently working, what date did you last work? _____

Review of Systems: Put a check next to any of the following symptoms that you have.

General:

- _____ Fever
- _____ Night sweats
- _____ Loss of appetite
- _____ Unexplained weight change
- _____ Lumps
- _____ Frequent headaches

Neurologic:

- _____ Numbness
- _____ Passing out
- _____ Dizziness
- _____ Weakness of muscles

Eyes:

- _____ Blurred vision
- _____ Double vision
- _____ See spots

Skin:

- _____ Rash
- _____ New mole
- _____ Change in size or color of mole
- _____ Non-healing sores
- _____ Colored lesion under nail(s)

Ear, nose, mouth, throat:

- _____ Ringing in ears
- _____ Decreased hearing
- _____ Hoarseness
- _____ Sore throat (chronic)

Psychiatric:

- _____ Depression
- _____ Bipolar
- _____ Other

Abdomen:

- _____ Pain
- _____ Nausea/vomiting
- _____ Constipation
- _____ Diarrhea
- _____ Blood in stool
- _____ Black stools

Endocrine:

- _____ Change in appetite
- _____ Cold or heat intolerance
(circle)
- _____ Frequently thirsty

Urinary System:

- _____ Blood in urine
- _____ Pain when urinating
- _____ Increased frequency of urination

Blood/Lymphatic systems:

- _____ Increase size of lymph nodes

Musculoskeletal:

- _____ Pain in joints (circle: hand, wrist, elbow, shoulder, neck, back, hip, knee, ankle, foot)
- _____ Joint swelling
- _____ Pain in muscles
- _____ Arthritis
- _____ Gout

List any recreational activities you do on a regular basis: _____

FAMILY HISTORY: List any relatives with major medical problems:

High Blood Pressure _____

Diabetes _____

Arthritis/Gout _____

Heart Attack _____

Cancer _____

Stroke _____

Other _____

Reviewed By: _____
Date: _____