Name:
DOB:
Chart:
Age:
Date:

HAND TO SHOULDER SPECIALISTS OF WISCONSIN

PATIENT HISTORY INFORMATION

Patient Name _____ **Date of Birth** _____

Occupation _____ **Gender** _____ **Marital Status** _____

Are you right or left handed? (please circle one)

What are you seeing the doctor for?

Injury / complaint: _____

Current Symptoms/Complaints: _____

_____

Date of Injury or Onset of Symptoms: _____

Please list all current medications, including non-prescription drugs:

_____

_____

Do you use medications to manage your pain? ____ **Yes** ____ **No**

If yes, what medication? _____ **Who prescribed this?** _____

Please list all previous surgeries, serious illnesses and/or injuries (even those not related to your hand problem):

_____

_____

_____

Please list all allergies, including food, drugs, latex, tape, etc:

_____

_____

Have you ever had problems with anesthesia? ____ **Yes** ____ **No**

If yes, please explain: _____

Do you use, or have you ever used tobacco? ____ **Yes** ____ **No** **Amount per day** _____

Do you drink alcohol? ____ **Yes** ____ **No** **Amount per day** _____

Do you consume caffeine? ____ **Yes** ____ **No** **Amount per day** _____

Do you use, or have you ever used, drugs for recreational or non-prescribed purpose?

____ **Yes** ____ **No** **What type** _____ **How much** _____ **Last used** _____

Name:
DOB:
Chart:
Age:
Date:

Height: _____ Weight: _____

Do you currently have, or have you ever had, any of the following: (Please circle Yes or No)

Allergies	Yes	No	
Cancer	Yes	No	
Are you currently pregnant?	Yes	No	
Are you currently breast feeding?	Yes	No	
RESPIRATORY:			
Respiratory/Breathing Problems	Yes	No	
Asthma/Shortness of Breath	Yes	No	
Tuberculosis/Pneumonia	Yes	No	
CARDIOVASCULAR:			
Heart Disease	Yes	No	
Heart Attack	Yes	No	
High Blood Pressure	Yes	No	
Chest Pain	Yes	No	
HEMATOLOGICAL:			
Blood Disorders/Anemia/ Blood Clots/Sickle Cell	Yes	No	
GI:			
Hepatitis/HIV	Yes	No	
Stomach Disorders/Ulcers	Yes	No	
Liver Disease	Yes	No	
GU:			
Urinary/Kidney Disorders/Frequency	Yes	No	
Genital Problems/Disease	Yes	No	
NEUROLOGICAL:			
Nerve Disorders	Yes	No	
Mental Health Conditions	Yes	No	
Weakness/Numbness/Tremors	Yes	No	
Headaches	Yes	No	
Seizures	Yes	No	
Stroke	Yes	No	
ENDOCRINE:			
Diabetes	Yes	No	
Thyroid Disease	Yes	No	
INTEGUMENTARY:			
Skin Disease:	Yes	No	
MUSCULOSKELETAL:			
Muscle/Bone Problems	Yes	No	
Osteoporosis	Yes	No	
Osteoarthritis or Rheumatoid Arthritis	Yes	No	
ENT:			
Ear/Nose/Throat/Eye Problems	Yes	No	

Do any of your blood relatives have a history of any of the above? No ____ Yes ____

Please explain: _____

_____

_____

_____ _____

Patient Signature Date Reviewed By Date