THE HAND CENTER
NORFOLK HAND SURGERY CENTER INC.

Patient's Name: _____ Today's Date: _____

DOB: _____ Height: _____ Weight: _____

Please Check the Line to the Left of Each Condition That Applies

___Difficulty swallowing
___Sleep apnea
___Headaches
___Head trauma/injury
___Bipolar Disorder
___Parkinson's
___Seizures
___Depression
___Anxiety
___Spinal cord injury
___Stroke
___Pacemaker
___Arrhythmia

___Heart attack
___Heart failure
___Heart disease
___Blood Clot or phlebitis
___Peripheral vascular disease
___Hypertension (high blood pressure)
___Hypercholesterolemia (high cholesterol)
___Mitral valve prolapse
___Chest pain
___Asthma
___Emphysema
___Pulmonary embolism
___Shortness of breath

___Diabetes
___Hepatitis
___Hiatal hernia
___Reflux/Heartburn
___Thyroid disease
___Arthritis
___Renal failure
___Anemia
___Cancer
Type: _____
___Excessive bleeding
___HIV/AIDS
___MRSA

___Other (Please list): _____
_____

Surgical History - Please Check the Line to the Left of Each Procedure That Applies

___Amputation
Body Part _____
___Back Surgery
___Cardiac Stent
___Carpal Tunnel Release

___Heart Bypass
___Hysterectomy
___Joint Replacement
Location _____

___Other (Please list)
_____
_____
_____
_____

Allergies to drugs, food, latex and other substances (include reactions): _____
_____
_____

Are you experiencing any pain? ___Yes ___No If yes, where and for how long? _____
How severe is your pain? ___None ___Mild ___Moderate ___Severe
Sensations: ___Sharp ___Dull ___Burning Other: _____

Substance History:
Tobacco: ___Yes ___No ___Quit ___Passive Quit Date: _____
If Yes, packs per day: _____ For how long? _____Years
Alcohol: ___Yes ___No ___Beer ___Liquor ___Wine Drinks per week: _____
Recreational Drugs: ___Yes ___No If yes, amount/times per week: _____

Female Patients:
Are you pregnant: ___Yes ___No If Yes, how far along are you? _____

List any special considerations or anything else you would like us to know: (ex. Hard of hearing, deaf, blind, cannot read &/or speak English, use walker or cane, on oxygen, etc) _____

Patient's Name: _____ Today's Date: _____

DOB: _____ Height: _____ Weight: _____

Medication List

Please list your medications (include over-the-counter medications as well as supplements and herbal remedies), the dosage, and how often you take each.

	Home Medications, Supplements, and Herbal Remedies	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			