Hand Surgical Associates
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Health Questionnaire

Please answer all questions completely and/or check appropriate boxes **Date: ____/_____/____**

Name: _____ **Person completing form: ☐Self ☐Other**
Date of Birth: _____/_____/_____ **Name/Relation: _____**
Height: _____Weight: _____ **Are you right or left handed? ☐Right ☐Left ☐Ambidextrous**

Current Occupation: _____
Prior Occupations: _____
Education completed: ☐Technical school, ☐High school, ☐College, ☐Graduate school

Describe your main problem:_____

Did you have an injury? ☐Yes ☐No If so how / when?_____
Which side is affected? ☐Right ☐Left ☐Both If both, which is worse? ☐Right ☐Left

When did it start? _____
What makes it better? _____
What makes it worse? _____
At night is it? ☐Better ☐Worse ☐No change

Describe pain (if present): ☐Burning ☐Sharp ☐Radiating (to: _____) ☐Constant ☐Intermittent
Pain location: ☐Neck ☐Shoulder ☐Arm ☐Elbow ☐Forearm ☐Wrist ☐Hand ☐ _____

Have you ever had similar symptoms? ☐Yes ☐No If yes, when? _____

Have you seen any other doctors for this problem? ☐Yes ☐No
If yes, please list: _____

(please bring all your medical records regarding this problem)

Please mark the treatment or tests you have had for this problem

☐ X-rays	☐ Myelogram	☐ Pain clinic treatment
☐ Arthrogram	☐ Hand therapy	☐ Nerve block
☐ CT scan	☐ Occupational therapy	☐ Trigger point injection
☐ MRI	☐ Physical therapy	☐ Cortisone injection
☐ EMG/NCV (nerve test)	☐ Acupuncture	☐ Chiropractic treatment

(please bring all the results and actual x-ray films or CD for this problem)

Is your problem work related: ☐Yes ☐No **Are you currently working? ☐Yes ☐No**
If No: When did you last work? _____/_____/_____
Do you have an attorney for this current problem? ☐Yes ☐No

(Please complete other side)

Health Questionnaire: Medical History (page 2)

Do you have any allergies to medicines? ☐ No ☐ Yes

Please list (if yes) :

Are you allergic to penicillin? ☐ No ☐ Yes **Allergic to latex?** ☐ No ☐ Yes

Are you taking any medication? ☐ No ☐ Yes *(you may add extra sheets as needed)*

Please list (if yes) :

Are you taking blood thinners? ☐ No ☐ Yes **: name** _____

Have you had any operations? ☐ No ☐ Yes *(you may add extra sheets as needed)*

Please list (if yes) :

Do you smoke tobacco? ☐ No ☐ Yes **If yes, how much and kind?** _____ **# years** _____

Do you drink alcohol? ☐ No ☐ Yes **If yes, how much and kind?** _____ **# years**_____

Are you pregnant? ☐ No ☐ Yes ☐ Possibly ☐ N/A

Do you have any of the following problems?

Heart arrhythmia	☐ No Yes ☐	Gall bladder	☐ No Yes ☐	Lung disease	☐ No Yes ☐
Heart attack	☐ No Yes ☐	Bowel	☐ No Yes ☐	Asthma	☐ No Yes ☐
High blood pressure	☐ No Yes ☐	Kidney	☐ No Yes ☐	Emphysema	☐ No Yes ☐
☐ Aortic or ☐ Mitral valve	☐ No Yes ☐	Bladder	☐ No Yes ☐	Tuberculosis	☐ No Yes ☐
Chest pain	☐ No Yes ☐	Diabetes	☐ No Yes ☐	Infectious disease	☐ No Yes ☐
Pacemaker	☐ No Yes ☐	Thyroid	☐ No Yes ☐	Hepatitis	☐ No Yes ☐
Circulation problem	☐ No Yes ☐	Arthritis	☐ No Yes ☐	Liver disease	☐ No Yes ☐
Stroke / TIA	☐ No Yes ☐	Gout	☐ No Yes ☐	Bleeding disorder	☐ No Yes ☐
Blood clot	☐ No Yes ☐	Rheumatic fever	☐ No Yes ☐	Healing	☐ No Yes ☐
Seizures	☐ No Yes ☐	Anxiety / Nervousness	☐ No Yes ☐	Cancer	☐ No Yes ☐
Anesthesia problems	☐ No Yes ☐	Depression	☐ No Yes ☐	Type:	

Within the past year, have you had any of the following?

Fever / Chills	☐ No Yes ☐	Shortness of breath	☐ No Yes ☐	Chest pain	☐ No Yes ☐
Weight loss or gain > 10 lbs	☐ No Yes ☐	Nausea / Vomiting	☐ No Yes ☐	Numbness or tingling	☐ No Yes ☐
Visual changes	☐ No Yes ☐	Ear / Nose / Throat problem	☐ No Yes ☐	Fractures (broken bones)	☐ No Yes ☐
Headaches	☐ No Yes ☐	Skin problem	☐ No Yes ☐	Back pain	☐ No Yes ☐
Dizziness / Fainting	☐ No Yes ☐	Bleeding problem	☐ No Yes ☐	Anxiety / Depression	☐ No Yes ☐

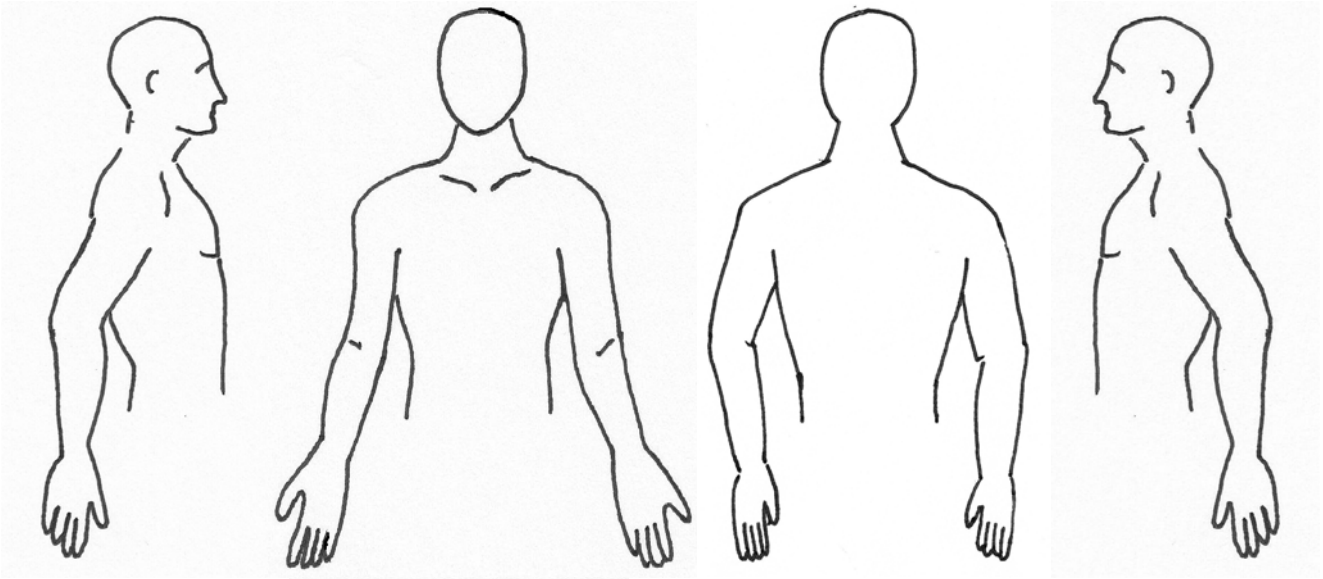
Do you have a family history of any of the following problems?

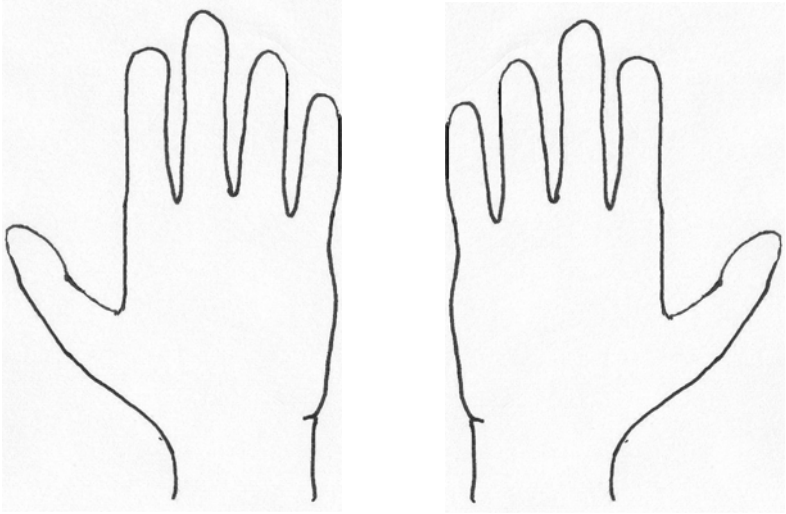
Heart disease	☐ No Yes ☐	Bowel disorder	☐ No Yes ☐	Vascular disease	☐ No Yes ☐
Heart attack	☐ No Yes ☐	Kidney disorder	☐ No Yes ☐	Stroke / TIA	☐ No Yes ☐
Aortic or mitral valve	☐ No Yes ☐	Bladder disorder	☐ No Yes ☐	Blood clot	☐ No Yes ☐
Rheumatic fever	☐ No Yes ☐	Diabetes	☐ No Yes ☐	Lung disease	☐ No Yes ☐
Pacemaker	☐ No Yes ☐	Thyroid disorder	☐ No Yes ☐	Bleeding disorder	☐ No Yes ☐
Arthritis	☐ No Yes ☐	Gout	☐ No Yes ☐	Cancer	☐ No Yes ☐
Anesthesia problems	☐ No Yes ☐			Type:	

Hand Surgical Associates 125 Parker Hill Ave Boston MA

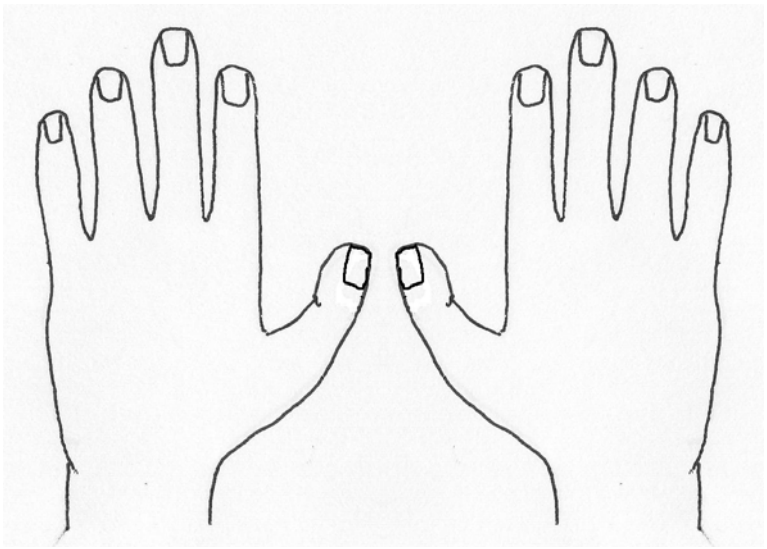
LAST NAME: **DATE: / /**

RIGHT **FRONT** **BACK** **LEFT**





LEFT **RIGHT**



Please mark the area(s) affected above

PAIN XXXXXX TINGLING ····· NUMBNESS ###### DECREASED SENSATION ///////