Hand & Wrist Surgery of NJ, LLC
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PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_____ Date of Birth:_____ Age:_____ Sex:_____

Name of Referring Doctor:_____Name of Family Doctor:_____

Which hand do you write with? Right / Left. Which hand has a problem? Right / Left / Both

Reason for Visit:_____

Duration of problem?_____ Rate your pain 0-10 (10 being the worst): ___ / 10

Are you allergic to any medications? (Please circle) Yes or No If Yes please list below:

DRUG ALLERGY	REACTION (rash, hives, ect.)	DRUG ALLERGY	REACTION (rash, hives, ect.)

List all current medications and dosages:

Past Medical History (please circle all that apply to you):

Diabetes	High Blood Pressure	High Cholesterol	Glaucoma	Cataracts
Heart Disease / Ht. attack	Congestive heart failure	Thyroid disease	Vascular disease	Aneurysm
Lyme disease	Bleeding disorder	Seizures	Depression	Anxiety
Multiple Sclerosis	Enlarged prostate	Hepatitis: Type A B C	Gastric Reflux	Anemia
Stomach ulcer	Rheumatoid arthritis	HIV Positive	Liver disease	Sleep apnea
Asthma	COPD / Emphysema	Cancer	Kidney disease	Gout

Please list any medical conditions you have that are not listed:

_____

Family History (please circle):

Diabetes	High Blood Pressure	Coronary artery disease	Bleeding disorder
Seizures	Hepatitis	Rheumatoid arthritis	Asthma
Cancer	Kidney disease	Dupuytren's contracture	Malignant hyperthermia

Please list any family medical conditions that are not listed above:

Past Surgical History (Please circle all that apply to you and list the date of surgery)

Surgery	Date	Surgery	Date
Knee arthroscopy: (Right / Left)		Shoulder arthroscopy: (Right / Left)	
Joint replacement surgery: (Knee / Hip)		Laparotomy	
Spine surgery: (Neck / Back)		Hernia Repair	
Eye surgery		Peripheral bypass surgery	
Coronary artery bypass graft		Cardiac catheterization	
Stents		Hysterectomy	

Please list any other surgeries you may have had in the past that are not listed:

Social History:

Please circle one: Single / Married / Partnered / Widowed / Divorced

Do you smoke? Yes or No Have you quit? Yes or No How much do you smoke?_____

Do you drink alcohol? Yes or No Please circle: Social only / Several times a week / Everyday

Do you or have you used illicit drugs? Yes or No If yes, what kind? Marijuana / Heroin / Cocaine

Education Level: Graduate level / College / Some College / HS Diploma / Trade

Occupation(s): _____

Sports: Golf / Tennis / Football / Baseball / Basketball / Running / Yoga / Gym / Bowling

Please circle any of the following symptoms that you have experienced recently:

CATEGORIES	SYMPTOMS		
Constitutional:	Fever	Night Sweats	Weight loss
Eye:	Red eyes	Blurring vision	Vision loss
Ears/Nose/Mouth:	Nose bleeds	Sore throat	Hearing loss
Cardiovascular:	Chest pain	Palpitations	Leg swelling
Respiratory:	Shortness of breath	Chronic coughs	Wheezing
Gastrointestinal:	Nausea	Vomiting	Diarrhea
Genitourinary:	Burning w/ urination	Blood in urine	Urinary incontinence
Skin:	Rash	Hives	Skin infection
Neurological:	Headache	Tremor	Seizures
Psychiatric:	Depression	Panic attacks	Suicidal ideation
Endocrine:	Excessive thirst	Cold intolerance	Excessive sweating
Hematological/Lymph	Easy bruising	Swollen glands	Easy bleeding
Allergy/Immune	Runny nose	Sinus congestion	Itchy eyes

Please describe the symptoms and treatment you have related to the problems checked above:

Any other important information you want your physician to know:

Patient Signature:_____ Date:_____