Fort Worth Hand Center

Texas Health Care, P.L.L.C

Please complete this form in its entirety at your first visit. It is the patient's responsibility to notify our office of any changes to the information listed on this form.

PATIENT DATA SHEET

Name _____ DOB _____ Date _____

PCP _____ Referring Physician _____

Briefly, what problem are you being seen for today?

_____

Date of Injury or Start of Symptoms _____

Affected Side (circle) Right Left Both

Dominant Hand (circle) Right Left

Past Medical Problems (e.g. diabetes mellitus, hypothyroidism, hypertension):

_____

_____

Previous Surgeries (include year performed, if known):

_____

_____

Current Medications (include dosages and frequencies, if known):

_____

_____

Allergies to Medications:

_____

Family History of Disease (e.g. significant for gout? Rheumatoid arthritis? Cancer?):

_____

Previous Upper Extremity Trauma (e.g. fractures? Dislocations? Motor vehicle accident?)

_____

Occupation _____

How long have you been at your current job? _____

Marital Status (circle) Single Married Divorced Widowed

Do you have children? Yes No If yes, how many? _____

Do you smoke? Yes No If yes, how many packs/day? _____

Do you drink alcohol? Yes No If yes, how many drinks/week? _____

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REVIEW OF SYSTEMS

Are you currently, or have you ever had problems with:

CONSTITUTIONAL				
Fever	☐	Yes	☐	No
Unexpected weight loss	☐	Yes	☐	No
Excessive fatigue	☐	Yes	☐	No
Night sweats	☐	Yes	☐	No
Loss of appetite	☐	Yes	☐	No
EYES				
Wear glasses or contacts	☐	Yes	☐	No
Infections	☐	Yes	☐	No
EARS, NOSE, THROAT				
Wear hearing aids?	☐	Yes	☐	No
Hearing loss	☐	Yes	☐	No
Ear infections	☐	Yes	☐	No
Balance Disturbance	☐	Yes	☐	No
Sinus problems	☐	Yes	☐	No
CARDIOVASCULAR				
Chest pain or angina	☐	Yes	☐	No
High blood pressure	☐	Yes	☐	No
Irregular pulse or heart beat	☐	Yes	☐	No
Heart murmur	☐	Yes	☐	No
Heart attack	☐	Yes	☐	No
Blood clots	☐	Yes	☐	No
RESPIRATORY				
Asthma	☐	Yes	☐	No
Bronchitis	☐	Yes	☐	No
Emphysema	☐	Yes	☐	No
Chronic cough	☐	Yes	☐	No
Shortness of breath	☐	Yes	☐	No
Pneumonia	☐	Yes	☐	No
Lung Cancer	☐	Yes	☐	No
Tuberculosis	☐	Yes	☐	No
GASTROINTESTINAL				
Ulcers or gastritis	☐	Yes	☐	No
Kidney Stones	☐	Yes	☐	No
Kidney disease	☐	Yes	☐	No

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GENITOURINARY

Urinary tract infections	☐	Yes	☐	No
Kidney stones	☐	Yes	☐	No
Kidney disease	☐	Yes	☐	No

INTEGUMENTARY

Skin cancer	☐	Yes	☐	No
Skin ulcers	☐	Yes	☐	No

MUSCULOSKELTAL

Broken bones	☐	Yes	☐	No
Arm/leg weakness	☐	Yes	☐	No
Arm/leg pain	☐	Yes	☐	No
Joint pain or arthritis	☐	Yes	☐	No
Osteoporosis	☐	Yes	☐	No
Back Pain	☐	Yes	☐	No
Scoliosis	☐	Yes	☐	No

NEUROLOGICAL

Balance problems	☐	Yes	☐	No
Headaches	☐	Yes	☐	No
Fainting spells	☐	Yes	☐	No
Seizures	☐	Yes	☐	No
Stroke	☐	Yes	☐	No

ENDOCRINE

Diabetes	☐	Yes	☐	No
Thyroid disease	☐	Yes	☐	No
Hormone problems	☐	Yes	☐	No

HEMATOLOGIC/LYMPHATIC

Anemia	☐	Yes	☐	No
Hemophilia	☐	Yes	☐	No
Blood Transfusion	☐	Yes	☐	No
Lymphoma/leukemia	☐	Yes	☐	No

ALLERGIC/IMMUNOLOGIC

Nasal allergies	☐	Yes	☐	No
Immunologic disorders	☐	Yes	☐	No

PSYCHIATRIC

Anxiety	☐	Yes	☐	No
Depression	☐	Yes	☐	No
Other	☐	Yes	☐	No

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The above information is accurate to the best of my knowledge:

_____ _____

Patient's Signature Date

I have reviewed the above information with the patient:

_____ _____

Physician's Signature Date