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.

NEW PATIENT INTAKE FORM

Name: _____ DOB: _____ PCP: _____

Chief Complaint: (Reason for today's visit) _____

Was your injury due to work: _____ Motor vehicle accident _____ Slip/Fall _____

Date of Injury: _____

Are you currently working? NO _____ YES _____ What is your occupation? _____

Do you smoke? NO _____ YES _____ (Packs/Day) _____ For how long? _____

Review of Systems: Do you currently have, or have had, problems with:

	(Circle)	(Please Describe)
Heart, Stroke, High blood pressure	NO/YES	_____
Lung, Breathing, Asthma	NO/YES	_____
Diabetes, Thyroid Disorder	NO/YES	_____
Bleeding Problems	NO/YES	_____
HIV/AIDS	NO/YES	_____
Cancer	NO/YES	_____
Skin	NO/YES	_____
Bowel or bladder problems	NO/YES	_____
Digestive or ulcer problems	NO/YES	_____
Arthritis/Gout	NO/YES	_____
Other medical problems	NO/YES	_____

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NEW PATIENT INTAKE FORM

Current Medications: _____

_____

Pharmacy: _____ Phone Number: _____

Allergies: _____

List any prior surgeries: _____

_____

List any family illnesses: _____

_____

Patient Signature: _____ Date: _____