SOUTHERN HAND CENTERS MEDICAL HISTORY FORM

Name:_____ Next MD visit date: _____

Any previous injury to involved area: yes no (circle one) Injury/onset of symptoms date: _____

Type of injury: (circle one) work-related athletic/recreational disease other

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CIRCLE any medical conditions below that apply to you:

Diabetes	Smoking	Pacemaker	Hepatitis
Seizures	Osteoarthritis	Heart Condition	Rheumatoid Arthritis
Lupus	Fibromyalgia	HIV/Aids	High Blood Pressure

If female, are you pregnant: yes no

Are you allergic to shellfish: yes no Are you allergic to latex: yes no

Are you taking any medication FOR YOUR UPPER EXTREMITY CONDITION: yes no

If yes, which types: (circle one) antibiotic pain anti-inflammatory/swelling

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Circle ALL activities you are having difficulty performing due to your upper extremity condition:

HOME:	laundry	groceries	trash	yard work
SELF-CARE:	dressing	grooming	bathing	meal prep
LEISURE:	hobbies	sports	recreation	_____

Describe your pain level AT THIS POINT in time using guidelines of:
1-3 mild, annoying 4-7 moderate limits activity 8-10 severe, inhibits activity

When you are RESTING and not using your arm	0	1	2	3	4	5	6	7	8	9	10
When you are MOVING your involved arm	0	1	2	3	4	5	6	7	8	9	10
When you are LIFTING or GRIPPING with involved arm	0	1	2	3	4	5	6	7	8	9	10

_____ _____
SIGNATURE OF PATIENT DATE