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: ______________________

CIRCLE any medical conditions below that apply to you:

Diabetes Type 1 Diabetes Type 2 Smoking Pacemaker Hepatitis

Alzheimer's Seizures Osteoarthritis Heart Condition Rheumatoid Arthritis

Immunosuppression Lupus Fibromyalgia HIV/Aids High Blood Pressure

Stroke Parkinson's History of Cancer Muscular Dystrophy Obesity Other: ____________

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	housekeeping	
	finances	medication management		transportation		
SELF-CARE:	dressing	grooming	bathing	meal prep	toileting	sleep
LEISURE:	hobbies	sports	recreation	shopping	__________________	
HAND/ARM USE:	throwing	reaching	catching	turning hand/arm	twisting hand/arm	
	grasping	releasing	manipulating	pulling object	pushing object	

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

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SIGNATURE OF PATIENT DATE