

Name:

Date:

DOB:

Chart:



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HEALTH HISTORY

Name: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____

Hand Dominance (right, left, ambidextrous): _____ Area affected (e.g. right hand): _____

Name of your primary care doctor: _____

Reason you were referred here: _____

Date of injury: ____ / ____ / ____ How long have you had this present condition? _____

Is this injury or condition work related? _____

What treatment have you had so far? _____

Do you have any of the following diseases?

YES	NO		YES	NO	
_____	_____	Asthma/Bronchitis	_____	_____	Stomach Ulcer / GERD
_____	_____	Emphysema	_____	_____	Liver Problem
_____	_____	Respiratory Disease	_____	_____	Kidney Problem
_____	_____	Tuberculosis	_____	_____	Hepatitis A B C D E
_____	_____	Anemia	_____	_____	Diabetes
_____	_____	High Blood Pressure	_____	_____	Thyroid - Hyper Hypo
_____	_____	High Cholesterol	_____	_____	Arthritis
_____	_____	Heart Problem / Pacemaker	_____	_____	Gout
_____	_____	Bleeding Problem	_____	_____	Epilepsy / Seizure Disorder
_____	_____	Blood Clot / DVT	_____	_____	Cancer
_____	_____	Stroke	_____	_____	Other
_____	_____	Family History of Anesthesia Problems	_____	_____	Family History of Diabetes
_____	_____	Family History of Bleeding Problems	_____	_____	Family History of Heart Disease

Please list all the medications you are taking:

Medications: _____ Dosage: _____ Frequency: _____

Are you allergic to any medications? YES _____ NO _____ If yes, what: _____

Are you allergic to anything else? YES _____ NO _____ If yes, what: _____

Have you had a tetanus shot? YES _____ NO _____ If yes, when: _____

Do you smoke? YES _____ NO _____ If yes, how much: _____ packs/day _____ years

Do you drink alcohol? YES _____ NO _____ If yes, how much: _____

Past Surgeries: _____

Patient's Signature: _____ Date: _____