

# JAIN HAND SURGERY CENTER CLINICAL HISTORY FORM

SSN: \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  Other DATE \_\_\_\_\_

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Legal Guard: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Physicain: \_\_\_\_\_ Primary Physician Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Work Comp Date of Injury: \_\_\_\_\_

Marital Status: (Please Circle) \_\_\_\_\_ Married Single Widowed Divorced Separated  
 Please initial below that you have received a copy of:  
 Notice of Health Information Practices \_\_\_\_\_

## Chief Complaint and Present Illness. To be completed by the physician or assistant.

**Reason for Consultation:**  Accidental Injury  Arthritis  Carpal Tunnel Syndrome  Fall  Tendon Rupture  Trigger Finger  
 Other: \_\_\_\_\_ LHD RHD

**Vital Signs:** Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Resp: \_\_\_\_\_ B.P. (sitting): \_\_\_\_\_ / \_\_\_\_\_ Pulse (sitting): \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

**If Symptom Includes Pain Check The One(s) That Best Describe:**  Aching  Burning  Continuous  Cramping  Deep  Dull  Gnawing  
 Gradual  Intermittent  Mild  Moderate  Periodic  Sharp  Shifting  Stabbing  Sudden  Superficial Other: \_\_\_\_\_

**Duration:** \_\_\_\_\_ **Location(s):** \_\_\_\_\_ **Historian:** \_\_\_\_\_

**Date Symptom(s) Began:** \_\_\_\_\_ **Frequency of Symptom(s):**  Constant  Intermittent  Occasional  Rare  Recurrent None

**Intensity of Symptoms:**  Excruciating  Mild  Moderate  Severe Other: \_\_\_\_\_

**How Did Symptom(s) Start:** \_\_\_\_\_

**How Did Symptom(s) Progress:** \_\_\_\_\_

**What Brings It On:** \_\_\_\_\_ **What Makes it Worse:** \_\_\_\_\_

**What Relieves It:** \_\_\_\_\_ **Associated Symptom(s):** \_\_\_\_\_

**Antibiotic Usage:** \_\_\_\_\_

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Medications - List all medications you are currently taking. Include ALL medications even the Over The Counter ones.

Drug Name (Generic/Brand)	Dosage	Frequency/Route	Status	Date Started/Stopped	Physician
			<input type="checkbox"/> Current <input type="checkbox"/> Chronic <input type="checkbox"/> DC'd		
			<input type="checkbox"/> Current <input type="checkbox"/> Chronic <input type="checkbox"/> DC'd		
			<input type="checkbox"/> Current <input type="checkbox"/> Chronic <input type="checkbox"/> DC'd		
			<input type="checkbox"/> Current <input type="checkbox"/> Chronic <input type="checkbox"/> DC'd		
			<input type="checkbox"/> Current <input type="checkbox"/> Chronic <input type="checkbox"/> DC'd		
			<input type="checkbox"/> Current <input type="checkbox"/> Chronic <input type="checkbox"/> DC'd		
			<input type="checkbox"/> Current <input type="checkbox"/> Chronic <input type="checkbox"/> DC'd		

**Allergies - List your allergies including any medications that caused an allergic reaction.**

List ALL Allergies

Allergic Reaction

List ALL Allergies	Allergic Reaction

**Past Medical History - Please provide a complete history including all illnesses, injuries, hospitalizations and operations.**

List All Illnesses, Injuries, Operations & Hospitalizations	Date	Hospital	Treatment	Physician	Response
Comments:	<b>Blood Type</b> <input type="checkbox"/> A + <input type="checkbox"/> A - <input type="checkbox"/> B + <input type="checkbox"/> B - <input type="checkbox"/> AB + <input type="checkbox"/> AB - <input type="checkbox"/> O + <input type="checkbox"/> O - <input type="checkbox"/> Other: _____				

**Family History - Please list all Blood Relatives with their current health status and any illnesses they have had or have.**

List Blood Relatives	Health Status	Age If Living	Age At Death	Cause Of Death	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					

**Social History - Please check the appropriate boxes and fill in the accurate amounts of standard portions.**

# Children: \_\_\_\_\_ Patient Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Mental Work:  Light  Moderate  Heavy Hours Per Day: \_\_\_\_\_ Occupation: \_\_\_\_\_

Physical Work:  Light  Moderate  Heavy Hours Per Day: \_\_\_\_\_

Exercise/Sports:  Light  Moderate  Heavy Hours Per Week: \_\_\_\_\_ Types Of Exercise/Sports: \_\_\_\_\_

Alcohol:  Never  Beer(s) \_\_\_\_\_ Per Week  Liquor \_\_\_\_\_ Per Week  \_\_\_\_\_ Wine Per Week How Many Years: \_\_\_\_\_

Smoking:  Never  Current  Discontinued Type: \_\_\_\_\_ Quantity: \_\_\_\_\_ How Many Years: \_\_\_\_\_

Miscellaneous Drugs:  Amphetamines  Antacids  Cocaine  Diet Pills  Laxatives  Marijuana  Nutrasweet  Pain Pills  Saccharin  Sleeping Pills  Vitamins  Other \_\_\_\_\_

Caffeine:  None Cups Per Day: \_\_\_\_\_ How Many Years: \_\_\_\_\_ Other: \_\_\_\_\_

Aspirin:  None Quantity Per Day: \_\_\_\_\_ How Many Years: \_\_\_\_\_ Other: \_\_\_\_\_

Nutritional Information:  Low Sodium Diet  Diabetic Diet  Low Fat Diet  Vegetarian Diet  Low Cholesterol Diet  Other: \_\_\_\_\_