

Alaska Hand-Elbow-Shoulder

Alaska's Premier Upper Extremity Surgical Specialists

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MEDICAL HISTORY

Name: Age: Height: Weight: Chart #:

MEDICAL HISTORY: Have you ever been treated for or had any problems with any of the following?

EYES	<input type="checkbox"/> Y <input type="checkbox"/> N	ENDOCRINE	<input type="checkbox"/> Y <input type="checkbox"/> N	GASTROINTESTINAL	<input type="checkbox"/> Y <input type="checkbox"/> N
Wear corrective lenses	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Nausea or vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N
Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Abdominal pain	<input type="checkbox"/> Y <input type="checkbox"/> N
EARS	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatoid disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Heartburn	<input type="checkbox"/> Y <input type="checkbox"/> N
Hearing loss	<input type="checkbox"/> Y <input type="checkbox"/> N	HEMATOLOGICAL/LYMPHATIC	<input type="checkbox"/> Y <input type="checkbox"/> N	URINARY	<input type="checkbox"/> Y <input type="checkbox"/> N
Hearing devices	<input type="checkbox"/> Y <input type="checkbox"/> N	Easy bleeding/bruising	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Ear disease or problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood clotting problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Infections	<input type="checkbox"/> Y <input type="checkbox"/> N
NOSE	<input type="checkbox"/> Y <input type="checkbox"/> N	Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	ORTHOPEDIC	<input type="checkbox"/> Y <input type="checkbox"/> N
Sinus problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis - Type: <input type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N
CARDIOVASCULAR	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N
Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> N	NEUROLOGIC	<input type="checkbox"/> Y <input type="checkbox"/> N	Gout	<input type="checkbox"/> Y <input type="checkbox"/> N
Irregular or fast heartbeat	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N	Bone/joint infection	<input type="checkbox"/> Y <input type="checkbox"/> N
Low blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures-epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Bone tumor/cyst	<input type="checkbox"/> Y <input type="checkbox"/> N
High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Stroke history	<input type="checkbox"/> Y <input type="checkbox"/> N	Artificial joint	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart disease or murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Paralysis of limbs	<input type="checkbox"/> Y <input type="checkbox"/> N	OTHER	<input type="checkbox"/> Y <input type="checkbox"/> N
RESPIRATORY	<input type="checkbox"/> Y <input type="checkbox"/> N	SKIN	<input type="checkbox"/> Y <input type="checkbox"/> N	Mental health history	<input type="checkbox"/> Y <input type="checkbox"/> N
Chronic or frequent cough	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin infections	<input type="checkbox"/> Y <input type="checkbox"/> N	Sleep apnea	<input type="checkbox"/> Y <input type="checkbox"/> N
Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Skin lesions	<input type="checkbox"/> Y <input type="checkbox"/> N	Pain Contract	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma or wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N	Recent tattoos	<input type="checkbox"/> Y <input type="checkbox"/> N		
Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	When: <input type="text"/>		Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left	
Tuberculosis history	<input type="checkbox"/> Y <input type="checkbox"/> N				

Who is your Primary Care Provider? **Females:** Are you pregnant at this time? No Yes

PAST SURGICAL HISTORY: Please list all operations that you have had and the surgeon who performed them:

<input type="text"/>	Date: <input type="text"/>
<input type="text"/>	Date: <input type="text"/>

FAMILY HISTORY: Please indicate who in your family has had any history as listed below.

Cancer: Heart disease: Lung problems: Diabetes: Gout:

Kidney problems: High Blood Pressure: Lupus: Arthritis: Rheumatoid arthritis:

PATIENT SOCIAL HISTORY: Do you drink alcohol? No Yes: Light/Social Occasional Moderate Heavy

If you quit using alcohol, how long since you quit?

Do you smoke? No Yes Packs/day? How long have you smoked?

If you quit smoking, how long since you quit? What is your occupation? # years:

Do you smoke marijuana or use any other illicit drugs? No Yes Type and how often?

Do you live alone? No Yes What are your living arrangements?

MEDICATIONS: Please list all medications you are taking including over the counter meds and vitamins. Check if NONE

Drug: Dose: Drug: Dose:

Drug: Dose: Drug: Dose:

ALLERGIES: Please list all drug allergies. Check if NONE

1. 2. 3.

*Patient/Guardian Signature: Date:

* By typing your name in this area you are stating the above information is true and correct to the best of your knowledge and this electronic form of signature will be treated the same as your original signature.

Comments: REVIEWED BY: Date: