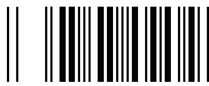

Patient's ID sticker will go here

Welcome!

Johns Hopkins Hand Surgery Patient History Questionnaire

Please fill out this questionnaire and bring it along to your appointment. The information you provide will help us focus on your immediate problems at the time of your visit.

PATIENT INFORMATION

Name: Age: Date of Birth: / /

Address: City:

State: Zip: Social Security #:

E-mail Address: Home Phone #:

Cell Phone #: Work Phone #:

Are You: ❑ Right-handed; ❑ Left-handed; ❑ Both Affected arm/hand: ❑ Right; ❑ Left; ❑ Both

Describe your work activity:

REFERRING PHYSICIAN INFORMATION

(This is the doctor who sent you to us.)

Please provide the address (including zip code) to which we may send a copy of your report.

Name: Specialty:

Address:

Office Phone #: Fax #:

PRIMARY CARE PHYSICIAN INFORMATION (This is the doctor who coordinates your care.)

Please provide the address (including zip code) to which we may send a copy of your report.

Name: Specialty:

Address:

Office Phone #: Fax #:

MAIN REASON(S) FOR YOUR APPOINTMENT:

CURRENT MEDICATIONS

Please list all the medications you take, including over-the-counter drugs.

Drug Name	*Does/Frequency*	*Prescribed by (Dr's name)*	*Taken Since (month/year)*

DRUG ALLERGIES AND REACTIONS

Are you allergic to any medications? If so, please list the medication and your reaction to it.

Medication	*Reaction*	*Medication*	*Reaction*

PAST SURGICAL HISTORY

Please list all the operations you have had, including the date of the surgery.

Procedure	*Date*	*Surgeon's Name*	*Result*

Have you ever had a problem with anesthesia? ❑ Yes ❑ No If yes, which anesthesia and what was the problem?

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, when? / / Reason:

PAST MEDICAL HISTORY

Please list other current medical problems and prior hospitalizations. (You may substitute a typed list if you already have one prepared.)

Problems or Hospitalization	*Date*

REVIEW OF HEALTH - GENERAL

Please place check (✓) in appropriate boxes

General Health
- ❑ Altered taste/smell
- ❑ Change in appetite
- ❑ Weight loss or gain
- ❑ Unable to sleep
- ❑ Excessive sleepiness
- ❑ Fatigue
- ❑ Fever

Ears, Nose, & Throat
- ❑ Balance problem
- ❑ Dizziness
- ❑ Ringing in ears
- ❑ Hearing loss
- ❑ Trouble breathing through nose
- ❑ Nose bleeds/discharge
- ❑ Sinus disease

Cardiovascular
- ❑ Chest pain
- ❑ Chest pressure
- ❑ Fainting
- ❑ Heart failure
- ❑ Heart murmur
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Shortness of breath
- ❑ Leg swelling

Blood/Endocrine
- ❑ Blood disorder
- ☐ Diabetes
- ☐ Endocrine disorder
- ❑ Sickle Cell Disease
- ❑ Thyroid disease
- ☐ Enlarged lymph nodes
- ❑ HIV
- ❑ AIDS

Skin
- ❑ Breast disease
- ❑ Skin rash
- ❑ Skin cancer

Eyes
- ❑ Blurred vision
- ❑ Double vision
- ❑ Glaucoma
- ❑ Cataracts

Respiratory
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Chronic cough

Gastrointestinal
- ☐ Abdominal pain
- ❑ Constipation
- ☐ Diarrhea
- ☐ Gastritis
- ❑ Hepatitis
- ❑ Hiatal hernia
- ☐ Rectal bleeding
- ❑ Ulcer
- ❑ Vomitting

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Trouble concentrating

Musculoskeletal

Joint
- ☐ pain
- ❑ swelling
- ☐ stiffness

Muscle Trouble
- ❑ atrophy
- ❑ cramps
- ☐ twitching
- ❑ weakness

Neck
- ❑ local pain
- ❑ shooting pain
- ❑ stiffness

- ❑ low back pain

Neurologic
- ❑ dizziness
- ❑ headaches
- ❑ speech difficulty
- ❑ facial numbness or tingling
- ❑ swallowing
- ❑ memory problems
- ❑ poor balance
- ❑ trouble walking
- ❑ poor hand coordination
- ❑ dropping objects from hands

Numbness
- ☐ arms or hands (right/left/ or both)
- ☐ legs (right/left/ or both)

Weakness
- ❑ arms or hands (right/left/ or both)
- ❑ legs (right/left/ or both)

FAMILY HISTORY

Is there a family history or orthopaedic (bone, joint) or neurologic (brain, nerve) problems similar to yours, or of other orthopaedic or neurologic problems? If so, please indicate who is or was affected.

Family Member	Problem

ADDITIONAL FAMILY HISTORY

Please place check (✓) in appropriate boxes.

	Father	Mother	Father's Parents	Mother's Parents	Brothers/Sisters	Children
Arthritis						
Bleeding disorder						
Brain Tumor						
Cancer						
Dementia						
Diabetes						
Epilepsy						
Heart Disease						
High blood pressure						
Kidney disease						
Neuromuscular disease						
Stroke						
Thyroid disease						

SOCIAL HISTORY

Are You: ☐ Single ☐ Married ❑ Widowed ❑ Separated ☐ Divorced

If you are married, what is your spouse's occupation? ____________________

Do you live: ☐ Alone ❑ with Spouse ☐ with Roommate ❑ with Parents/Siblings

What is your highest level of education? ❑ High School ☐ Vocational School ☐ College ❑ Graduate School

What are your hobbies? ____________________

Have you ever smoked ❑ Yes ☐ No How many packs per day? ______ For how long?___________ When did you stop?____/____/_____

Do you drink alcohol? ☐ Yes ❑ No How much per week? ❑ For how long?____________ When did you stop?____/____/_____

Is there anything else we should know about you or your condition? ____________________

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