DATE___________

PATIENT INFORMATION

Name ___________________________________ Age ______ Sex M☐ F☐ DOB __________

Primary Care Physician ___________________________ Referred By ____________________

Which hand do you write with? Right ☐ Left ☐

CHIEF COMPLAINT

Reason for today's visit ____

Is this injury related to ☐ Auto Accident ☐ Work related ☐ Other _______________________

Onset of symptoms ☐ Sudden ☐ Gradual ☐ Date of onset _____________________________

How did your injury occur/symptoms begin? _______________________________________

Check which best describes your current symptoms/complaint (please check all that apply)

☐ Pain	☐ Stiffness	☐ Giving out
☐ Swelling	☐ Tingling	☐ Locking
☐ Bruising	☐ Popping	☐ Other ____________________
☐ Numbness	☐ Weakness	

What makes this better? ____________________________ worse? _____________________

What is your pain level 0 1 2 3 4 5 6 7 8 9 10

Have you been seen by another provider for this problem? ☐ Yes ☐ No When? ____________

What treatments have you had, if any? ____

PAST MEDICAL HISTORY

☐ Asthma	☐ Gout	☐ Diabetes	☐ Neurological Disease
☐ COPD	☐ Osteoporosis	☐ Bleeding Tendencies/ Blood Clots	☐ Stroke/TIA
☐ Rheumatologic Disease	☐ Heart Disease	☐ Sleep Apnea	☐ Liver Disease
☐ Osteoarthritis	☐ High Blood Pressure	☐ Thyroid Disease	☐ Hepatitis
☐ Varicose Veins	☐ Cancer	☐ History of Substance Abuse	☐ High Cholesterol
☐ Stomach/Bowel	☐ Kidney Disease	☐ Anxiety/Depression	☐ Other

PAST SURGICAL/HOSPITALIZATION HISTORY

Reason	Date

MEDICATIONS (Include all prescription, over the counter, vitamins, and herbals)

Name	Reason for Taking Medication	Dosage

ALLERGIES (Medications, Dyes, Latex, Adhesive Tape, Anesthesia, Environmental ☐ None

HEALTH REVIEW (Please check if you are currently experiencing any of the following)

	Weight Changes		Fever		Night Sweats		Rashes
	Bleeding/bruising		Headaches		Dizziness/Fainting		Fatigue
	Visual Changes		Chest Pain/ shortness of breath		Palpitations		HIV/AIDS
	Circulatory problems		Ears Ringing		Swollen lymph nodes		
	Abdominal Pain/Ulcers		Nausea/vomiting		Diarrhea/Constipation Bloody/black stools		
	Frequent/painful Urination		Post menopausal		Cough		

Patient signature____ Date _______________

Physician's signature______________________________________ Date _______________

ORTHO.BOSTON HAND SYMPTOMS

CIRCLE ALL THAT APPLY

Symptoms:

NUMBNESS	SWELLING	ACHINESS
TINGLING	STIFFNESS	SHARP PAIN
CLICKING	DULL PAIN	GIVING AWAY
SPASM	WEAKNESS	

Difficulty or pain with:

PULLING	PUSHING	GRASPING
RAISING ARM	TYPING	WRITING
HOLDING PHONE		