St Luke's

# St. Luke's Clinic - Orthopedics Hand & Wrist Clinic

## Personal and Confidential Health History

Name: _____ Age: _____ Date Of Birth: _____

Right/ Left handed: _____ Current Occupation: _____ Hobbies/Interest: _____

Is your current problem a result of: ___ Car Accident ___ Work Accident ___ Other Accident ___ Unknown

Is this a second opinion: ___ Yes ___ No If yes, please list other physicians involved in your care:_____

_____

Approximate date of onset and/or duration of your condition: _____

As specifically as possible, please locate your pain: _____

Rate your pain, on a scale of 1 – 10: _____ (0 = No Pain and 10= Severe pain)

Do you have pain that wakes you at night? ___ Yes ___ No
Do you have numbness in your hands and arms? ___ Yes ___ No
Do you have weakness in your hands and arms? ___ Yes ___ No
Are you able to participate in activities you enjoy? ___ Yes ___ No If No, please explain _____
Are you able to perform Activities of Daily Living? ___ Yes ___ No If No, please explain _____
Are you able to perform your normal work place responsibilities? ___ Yes ___ No If No, please explain _____
Have you undergone previous treatment for this condition? ___ Yes ___ No If Yes, please explain _____
How have you managed your symptoms up to this point? _____
Do you currently take medication (Prescription or non-Prescription) for your condition? ___ Yes ___ No If Yes, Please list below:
_____

### Personal Medical History:

Do you have a personal history of:

___ Diabetes ___ Cancer ___ Infectious Disease ___ Hepatitis A/B/C ___ HIV ___ C-Difficile ___ MRSA ___ Heart Problems

List all other current medical problems: _____

_____

### Past Surgical and Hospitalization History:

| Surgery/Hospitalization | Year | Reason | Surgery/Hospitalization | Year | Reason |
|---|---|---|---|---|---|
| 1. _____ | | | 5. _____ | | |
| 2. _____ | | | 6. _____ | | |
| 3. _____ | | | 7. _____ | | |
| 4. _____ | | | 8. _____ | | |

### Current Medications:

| Medication | Dose | Reason | Medication | Dose | Reason |
|---|---|---|---|---|---|
| 1. _____ | | | 5. _____ | | |
| 2. _____ | | | 6. _____ | | |
| 3. _____ | | | 7. _____ | | |
| 4. _____ | | | 8. _____ | | |

## ALLERGIES:

Latex Allergy: ___ No ___ Yes

| Medication Allergy | Reaction | Medication Allergy | Reaction |
|---|---|---|---|
| 1. _____ | | 4. _____ | |
| 2. _____ | | 5. _____ | |
| 3. _____ | | 6. _____ | |

## Family Medical History:

| Family Member | Alive/Deceased | Age | Health Status or Cause of death |
|---|---|---|---|
| Mother | A/D | _____ | _____ |
| Father | A/D | _____ | _____ |
| _____ | A/D | _____ | _____ |
| _____ | A/D | _____ | _____ |

## Social History:

Relationship Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Cohabitate

Do you exercise: ___ Yes ___ No How Frequently: ___ Never ___ Rarely ___ Monthly ___ Weekly ___ Daily

What type of exercise: _____

Do you use tobacco products: ___ No ___ Yes Which products: ___ Smoke ___ Smokeless ___ Vapor

Amount per day: _____ For how long: _____ OR, when did you quit: _____

Do you have a history of substance abuse: ___ No ___ Yes If Yes, which substance: _____

Do you drink Alcohol: ___ No ___ Yes If yes, how often and how much: _____

## Review of System: (are you currently having or have you had in the last three months)

| | | |
|---|---|---|
| Skin: wound healing, skin infection, other | Yes / No | _____ |
| Endocrine: Diabetes, thyroid, estrogen, other | Yes / No | _____ |
| Cardiac: chest pain, angina, heart irregularities | Yes / No | _____ |
| Pulmonary: asthma, chronic cough, shortness of breath | Yes / No | _____ |
| Kidney: infection, stones, failure, other | Yes / No | _____ |
| GI: malabsorption, diarrhea, constipation, liver failure | Yes / No | _____ |
| Nervous: stroke, tremor, cerebral palsy, other | Yes / No | _____ |
| Vascular: stroke, blood clots, cool or cold extremities | Yes / No | _____ |
| Musculoskeletal: gout, arthritis, other | Yes / No | _____ |
| Mental Illness: depression, bipolar, mood swings, other | Yes / No | _____ |

Please list any other health issues: _____

What is your preferred language? _____ Interpreter needed? ___ No ___ Yes
Do you learn best by: ___ Visual ___ Demonstration ___ Pictures/Video ___ Audio ___ Other _____
Do you have any barriers to learning? (Check all that apply) ___ Reading ___ Language ___ Visual ___ Hearing ___ Physical
___ Emotional ___ Cognitive ___ Financial ___ Spiritual ___ Cultural ___ Other: _____

**Patient Signature:** _____ **Date:** _____