THE REGIONAL HAND CENTER OF CENTRAL CALIFORNIA
2139 E. Beechwood Avenue
Fresno, CA 93720

PERSONAL HISTORY

DATE OF EXAM:	DATE OF INJURY:

NAME:

LAST FIRST MIDDLE

DOB:	AGE:	DOMINANT HAND: R / L

PAST MEDICAL HISTORY: Check all that apply

___ Asthma
___ COPD/ Emphysema
___ Heart Disease
___ Stroke
___ Heart Attack
___ High Blood Pressure
___ Kidney Disease
___ Liver Disease
___ Diabetes
___ Bleeding Disorder
___ Migraines
___ Reflux Disease (Heart Burn)
___ Peptic Ulcer Disease
___ HIV / AIDS
___ Hepatitis
___ Lupus / Collagen Vascular Disease
___ Previous Hand Injury
___ Gout
___ Arthritis
___ Thyroid Disease
___ Cancer

___OTHER____

____

___ NONE

PAST SURGICAL HISTORY ___ **NONE**

DATE	PROCEDURE

CURRENT MEDICATIONS: ___ **NONE**

DRUG	DOSE	FREQUENCY

ALLERGIES TO MEDICATIONS: ___ **NO KNOWN DRUG ALLERIES**

DRUG	REACTION

Name: **Acct:**

SOCIAL HISTORY

MARITAL STATUS ___ Single ___ Married ___ Widowed ___ Divorced

EDUCATION ___ Elementary ___ High School ___ College ___ Graduate

DO YOU SMOKE? Yes / No IF YES, # of packs _______________ # of years ______________________

DO YOU DRINK? Yes / No IF YES, # Drinks ____________________________ # of years__________

SMOKED OR DRANK IN THE PAST? ____

DO YOU (OR HAVE YOU) USED ILLEGAL DRUGS?____

DO YOU HAVE CHILDREN?__________ HOW MANY?______________________________________

HOBBIES____

FAMILY HISTORY (ANYONE IN THE FAMILY HAVE MEDICAL PROBLEMS SUCH AS DIABETES, HEART PROBLEMS, ETC.)

MATERNAL ____

PATERNAL ____

REVIEW OF SYSTEMS:

Please check all symptoms that have occurred within the last one or two months:

GENERAL
___ Weight changes
___ Fevers/chills
___ Night Sweats
___ Fatigue

EYE
___ Visual changes
___ Dry eyes
___ Eye infection

ENDOCRINE
___ Heat/cold intolerance
___ Radiation exposure

EAR, NOSE, THROAT
___ Difficulty hearing
___ Tinnitus (ringing in ear)
___ Epistaxis (nose bleed)
___ Hoarseness
___ Sinusitis

PULMONARY
___ Cough / Sputum
___ Shortness of Breath
___ Wheezing
___ Tuberculosis
___ Sleep Apnea
___ Pneumonia

CARDIOVASCULAR
___ Chest Pain
___ Palpitations
___ Syncope (fainting)
___ Calf pain with walking
___ Edema (swelling) in legs
___ Peripheral vascular disease
___ Elevated cholesterol

NEUROLOGIC
___ Headaches
___ Seizures
___ Weakness
___ Vertigo / dizziness
___ Pain / sensory changes
___ Stroke

GASTROINTESTINAL
___ Nausea / vomiting
___ Difficulty Swallowing
___ Abdominal Pain
___ Blood in stool
___ Diarrhea / constipation
___ Jaundice
___ Hemorrhoids

GENITOURINARY
___ Increased urine frequency
___ Pain with urination
___ Sexually Transmitted Disease
___ Bladder infection
___ Difficulty passing urine

HEMATOPOETIC
___ Anemia
___ DVT (clot in veins)
___ Do you use Aspirin?
___ Do you use Advil/Motrin?
___ Do you use Coumadin?

MUSCULOSKELETAL
___ Joint stiffness
___ Joint pain
___ Joint swelling

PSYCHIATRIC
___ Anxiety
___ Depression
___ Sleep disorder
___ Loss of control / violence
___ Substance abuse
___ Relationship difficulties

___ ALL NEGATIVE

Name: **Acct:**

CHIEF COMPLAINT: ____

____

HISTORY OF PRESENT ILLNESS (cause of accident/injury):__________________________

____

____

____

PREVIOUS MEDICAL TREATMENT: ____

____

____

LOCATION OF TREATMENT:____

Check all treatments that you were given, and write on the side where they were performed:

___ X-Rays	___ Tetnus shot	___ Antibiotics
___ Pain medicine	___ Anti-inflammatory meds	___ Steroid shot
___ Physical therapy	___ Splints	___ MRI / CT scan
___ Nerve conduction study	___ Bone scan	___ Arthrogram

JOB DESCRIPTION (Workers' Compensation only)

DATE HIRED__________________ JOB TITLE ____

HOURS WORKED PER DAY _______________ HOURS WORKED PER WEEK _________________

ARE YOU CURRENTLY WORKING? YES / NO LAST DAY OF REGULAR DUTY____________

DESCRIBE JOB DUTIES:____

____

____

____

____

AVERAGE WEIGHT LIFTING_________________ MAX WEIGHT LIFTING____________________

FREQUENCY OF WEIGHT LIFTING____

Name: **Acct:**

OTHER SOURCES OF INCOME / SECOND JOB ____

____

____

I have completed this personal medical history form to the best of my ability. All of the information is true and correct.

PATIENT SIGNATURE: ____ DATE: ______________

I have reviewed this information with this patient.

PROVIDER: ____ DATE: _____________

Randi A. Galli, M.D .Ricardo Avena, M.D.