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) ___ **NONE**

- ___ **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**
- ___ **Are you taking a blood thinner or anti-platelet medication?**
- ___ **OTHER**____
- ___ **HAVE YOU OR ARE YOU BEING FOLLOWED BY A CARDIOLOGIST? Dr.** ______________

PAST SURGICAL HISTORY ___ **NONE**

DATE	PROCEDURE

CURRENT MEDICATIONS: ___ **NONE**

DRUG	DOSE	FREQUENCY

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

DRUG	REACTION

Pharmacy: ______________________ **City:** ______________________

Name: **Acct:**

SOCIAL HISTORY

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?____

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

MATERNAL ____

PATERNAL ____

HISTORY OF PRESENT ILLNESS (how did this accident/injury occur):

____

____

____

____

LOCATION OF TREATMENT: ____

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

___ X-rays ___ Tetanus 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:**

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:** ______________

Randi A. Galli, M.D. Ricardo Avena, M.D. Ryan Stehr, M.D.
Ileana Cervantes, PA-C Eric Wagoner, PA-C Evan Mangubat, PA-C Richard Green, PA-C