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