Fort Lauderdale *Hand* Clinic

THERAPIST-OWNED UPPER EXTREMITY REHABILITATION

Patient Medical History

Date: ___________ Name: ___________________________________ Date of Birth: ________________ Age: _________

Current Occupation:_____________________________________ Dominance (circle which hand you write with) Right Left

Which Hand Is Injured (circle): Right Left Insurance Company: ____

Date of Current Injury: _____________________ Date of Current Surgery(s): ______________________________

How were you injured (briefly)? : ____

Where did your injury occur (circle one)? At home / At work Other: ____

Previous Surgical Procedure(s) Involving the Same Hand:____

Drug Allergy(s): ____

Other Medical Issues (circle all that apply): Diabetes / Elevated Blood Pressure / Elevated Cholesterol / Cardiac History

Osteoarthritis / Rheumatoid Arthritis / Osteoporosis Other: ____

____

Medications/Vitamins	Dosage	Frequency: Once/day, BID, TID	Form: Pill, Injection etc.

How would you rate your current level of pain? On a scale from 0 to 10, with 0 being no pain at all and 10 being the worst pain you have ever had (circle one)?

Best 0 1 2 3 4 5 6 7 8 9 10 Worst

Medicare Only

Are you currently receiving Home Health Care? (circle one) Yes No Permanent Residency_______________(State)