Name _____ **Date of Birth** ___/___/_____ **Today's Date** ___/___/_____

☐ Male ☐ Female Height _____ Weight _____

Reason for Visit _____

Office Use Only
Temp _____

Prior Surgeries and Hospitalizations:

_____
_____
_____
_____
_____
_____

Current Medications:

_____
_____
_____
_____
_____
_____

Surgical Issues (check all that apply)

☐ Anesthesia problems (you or a close relative)
☐ Bleeding disorder or on a blood thinner
☐ Loose / removable dental work
☐ Pregnant / possibly pregnant
☐ Objection to blood transfusion
☐ Nausea following anesthesia
☐ Contact lenses
☐ Reflux or heartburn
☐ Sleep apnea
☐ **None**

Comments: _____

Allergies (medications, LATEX or other): Please indicate the reaction (e.g. hives, rash, difficulty breathing) ☐ **No allergies**

_____ _____
_____ _____

			Comments
Head and Neck			
☐ Yes	☐ No	Jaw pain (TMJ pain)	_____
☐ Yes	☐ No	Neck stiffness	_____
Respiratory			
☐ Yes	☐ No	Smoker	_____
☐ Yes	☐ No	Shortness of breath	_____
Cardiovascular			
☐ Yes	☐ No	High blood pressure	_____
☐ Yes	☐ No	Stroke	_____
☐ Yes	☐ No	Coronary artery disease (angina, prior heart attack)	_____
☐ Yes	☐ No	Congestive heart failure	_____
☐ Yes	☐ No	Irregular rhythm	_____
☐ Yes	☐ No	Heart murmur	_____
☐ Yes	☐ No	Peripheral vascular disease	_____
Gastrointestinal/Renal			
☐ Yes	☐ No	Ulcers	_____
☐ Yes	☐ No	Liver problems	_____
☐ Yes	☐ No	Kidney failure	_____
Musculoskeletal			
☐ Yes	☐ No	Arthritis	_____
☐ Yes	☐ No	Osteoporosis/osteopenia	_____
☐ Yes	☐ No	Artificial joints	_____
Neurologic			
☐ Yes	☐ No	Seizures	_____
☐ Yes	☐ No	Paralysis	_____
Metabolic			
☐ Yes	☐ No	Diabetes	_____
☐ Yes	☐ No	Thyroid disease	_____
Infectious Disease			
☐ Yes	☐ No	HIV	_____
☐ Yes	☐ No	Hepatitis (B,C)	_____
☐ Yes	☐ No	MRSA (past or present)	_____
Social			
☐ Yes	☐ No	Alcohol or recreational drugs	_____

Office Use Only

Reviewed by MD

Sig _____
Date ____/____/_____

Reviewed by MD

Sig _____
Date ____/____/_____

Reviewed by patient
☐ No changes from prior
☐ Changes noted
Date ____/____/_____

Reviewed by patient
☐ No changes from prior
☐ Changes noted
Date ____/____/_____

Reviewed by patient
☐ No changes from prior
☐ Changes noted
Date ____/____/_____

Seattle Hand