THE HAND CENTER

OF WESTERN MASSACHUSETTS
3550 Main Street, Suite 204
Springfield, MA 01107
(413) 733-2204
Fax (413) 734-0587

Medical Questionnaire

Name____
Last First Middle

Home Address ____

City, State, Zip ____ Email ____________________

Telephone Home _______________________ Work ____________________ Cell ___________________

License Number ________________________________ Date of Birth ____________________________
(If parent or legal guardian list your License)

Marital Status: ____________________Spouse/Significant Other Name: _______________________________

Personal Physician ____
Name Telephone Number

____
Street Address City State Zip Code

What hand is dominant? Left ___ Right ___ Occupation: ____________________________________

Reason for this evaluation: ____

____

Name of the insurance plan to be billed: ____

Name of subscriber: ____________________________________ Subscriber date of birth: _________________

Is this injury the result of an accident? Yes ___ No ___ If yes, please provide the date: ______________________

Is the accident associated with one of the following:

Work place injury? Yes ___ No ___ Motor vehicle accident? Yes ___ No ___ Other party liability? Yes ___ No ___

Other_______ Please explain:____

____

If Liability or "Other" applies, is this something you plan to pursue? Yes ____ No____

List any relevant family history: ____

Operations that you have had (Procedure, Date, Surgeon): ____

____

____

Medical Allergies: ____

Illnesses or Medical Conditions that you have had or have now: ______________________________________

____

____

Medications (Name, Dose, Frequency) List All, Including Aspirin and herbal supplements, i.e. ginkgo biloba, ginseng, kava: ____

____

____

Do you take blood thinning medication? Yes____ No____ If yes, name of medication: _________________________

Do you smoke? Yes___ No ____ If yes, how many packs per day? ______ If yes, how many years? ______________

Have you smoked in the past? Yes___ No ____ If yes, how many packs per day? ____ If yes, how many years? ______

Does anyone in your household smoke? Yes ___ No ___

Do you drink alcohol? Yes ___ No ___ If yes, how much? _____________________

History of Substance Abuse Yes ___ No ___

Review of Systems

During the last 6-12 months have you experienced any changes in the following area (s)? Please circle yes or no for each

Constitutional: Recent Changes			Gastrointestinal	Y	N	Neck/ Cervical	Y	N
Temp _______	Y	N	Stomach	Y	N	Spine	Y	N
Weight _______	Y	N	Liver	Y	N	Pain	Y	N
Height _______	Y	N	Intestinal	Y	N			
Pulse/Heart Rate	Y	N	Bowel	Y	N			
Hypertension								
Eyes: Visual Changes	Y	N	Renal/Bladder	Y	N	Respiratory- Lungs	Y	N
Glasses	Y	N	Genitourinary	Y	N			
			Kidneys	Y	N			
Ears, Nose & Throat:	Y	N	Musculoskeletal	Y	N	Cardiovascular	Y	N
Hayfever	Y	N	Arthritis (where)	Y	N	Heart	Y	N
Throat URI	Y	N	Shoulder	Y	N	Circulation	Y	N
Tinnitus	Y	N	Spine	Y	N			
Skin Rash	Y	N	Neurologic	Y	N	Psychiatric	Y	N
Chronic Condition	Y	N						
Endocrine- Diabetes	Y	N	Gynecological	Y	N	Do you have a pacemaker?	Y	N
Thyroid	Y	N	Pregnancy	Y	N			

How did you hear about us? Please check as many boxes as apply:

Doctor ____ Insurance Carrier ____ Employer ____ Internet _____ Friend/Relative _____ Other_________________

Print Name: ____ Relationship: ______________________

* If patient is a minor, print name of parent or guardian

Signature: ____ Date____________________________

* Patient or if patient is a minor parent or guardian