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 _____

SS Number (required) _____ Date of Birth _____

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____

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 any blood thinner 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? _____

Does anyone in your household smoke? Yes ___ No ___

Do you drink alcohol? Yes ___ No ___ History of Substance Abuse Yes ___ No ___ _____

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

_____

_____

Review of Systems

During the last 6 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
			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	Y	N						
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	Y	N
Thyroid	Y	N	Pregnancy	Y	N	pacemaker?		

How did you hear about us? <u>Please check as many boxes as apply</u>:

Doctor ____ Insurance Carrier ____ Yellow Pages ____ Civic Center Sign _____ Employer ____ Internet _____

Newspaper ____ TV Commercial ____ Friend/Relative _____ Other_____

Print Name: _____ Relationship: _____

* If patient is a minor, a parent or guardian must sign

Signature: _____ Date_____

* Patient, parent or guardian