



# 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 \_\_\_ Does anyone in your household smoke? Yes \_\_\_ No \_\_\_

If yes, how many packs per day? \_\_\_\_\_ If yes, how many years? \_\_\_\_\_

Do you drink alcohol? Yes \_\_\_ No \_\_\_ History of Substance Abuse \_\_\_\_\_

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

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

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