MEDICAL HISTORY FORM

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3. **Email** back to admin@myhand.com.au
4. **Print Copy** & bring to Consult

NAME

Age Male Female Height cm Weight kg

Hand Dominance **Occupation**

Marital Status

If retired what did you do previously?

What **SPORT** / Hobbies do you play/ do?

Previously??

When did you **first notice your problem**? ____ days _____months _____ years or Date:

INJURY ASSESSMENT - If applicable.

1. Date of Injury:

2. Side of Injury?

3. What was injured?

Other injuries

4. Where did injury Occur?

Other....

5. What were you doing at the time of the accident?

Other

What **PROBLEMS** have you noted??? Indicate all

- ◯ Pain
- ◯ Catching
- ◯ Waking from Sleep
- ◯ Sprain
- ◯ Swelling / Lump
- ◯ Weakness
- ◯ Deformity
- ◯ Fracture
- ◯ Stiffness
- ◯ Numbness
- ◯ Colour change
- Other
- ◯ Clicking
- ◯ Tingling
- ◯ Abnormal sweating

What **TREATMENT** have you had so far???

- ◯ None
- ◯ Rest
- ◯ Splint
- ◯ Cast
- ◯ Pain Killers
- ◯ Anti-Inflammatories
- ◯ Injections
- ◯ Physio
- ◯ Surgery

Date of Surgery

Other

PAIN Assessment On a Scale of 0 - 10 how do you rate your pain?? 0 = No pain, 10 = The worst pain you could imagine eg Your leg being chopped off with a chain saw!

Pain at Best Pain when Worst

Does the Pain **WAKE** you from SLEEP?? YES NO How often do you wake / week?? / Week

What things relieve the pain?? ______

What things are you unable to do?? ○ Work Full duties ○ Work Light Duties ○ Drive ○ Housework

○ Open Jars ○ Fine manipulation eg Buttons Other ______

GENERAL HEALTH Please indicate if you have or have had any of the medical conditions listed.

○ Angina / Heart Attack	○ Venous Thrombosis DVT Clotting	○ Osteoarthritis
○ Hypertension Blood pressure	○ Pulmonary Embolus Clot to lung	○ Rheumatoid arthritis
○ Diabetes	○ Bleeding problems	○ Gout
○ Cholesterol (High)	○ Hepatitis	○ Osteoporosis
○ Stroke	○ HIV / AIDS	○ Previous fractures
○ Kidney Disease	○ Reflux / Heart Burn	○ Polycystic Ovary Syndrome
○ Lung Problems	○ Psoriasis	○ Anxiety
○ Asthma	○ Haemochromatosis	○ Depression
○ Cancer	○ Thyroid disease	Other ______
Type of Cancer ______	○ Recent Viral Illness	

List any **OPERATIONS** you have had. ○ Carpal Tunnel ○ Trigger finger ○ Joint Replacement ○ Prostate

○ Thyroid ○ Gall Bladder ○ Heart Bypass ○ Stent ○ Hysterectomy ○ Spine ○ Arthroscopy

Other ______ Have you had problems with operations?

Are there any conditions which run in your **Family**? ○ Arthritis ○ Gout ○ Psoriasis ○ Diabetes

○ Dupuytrens disease Other ______

Please list all **ALLERGIES** No Allergies Penicillin Keflex Sulphur Sticking Plaster

Tet Tox Lyrica Gabapentin Other

Do you **SMOKE**?? Yes No Previously How many / Day How many years have you smoked?

How many glasses of **ALCOHOL** do you drink / week? ______ Previously more ? ______

What MEDICATIONS are you taking now?? Warfarin Plavix Xarelto Eliquis Aspirin Zyloprim

Pain Medications ______

Other Medications

Signature ______ Date