San Antonio Hand to Shoulder Orthopaedic Center

Mark A. Katz, M.D.

Past Medical History

Date: _____ Patient Date of Birth: _____ Age:_____

Patient First Name: _____M.I._____Last:_____

Ht:_____ Wt: _____ B/P: _____ Pulse_____

Primary Care/Family Doctor: _____Referred By: _____

Major Complaint(s) or Injury :
Hand/Wrist: Right Left **Elbow:** Right Left **Hand Dominance:** Right HD Left HD Ambidextrous

Problem:_____

_____

_____

How and when did it happen? _____

Are there prior injuries to this area(s): ____ Yes ____ No

Is this work related? ____Yes ____ No If yes, Date of Injury_____

Is this a sport injury? ___ Yes ___ No If so, School Name: _____

Is an attorney involved? ____ Yes ____No If so, name: _____

SOCIAL HISTORY:

Do you smoke? ___ Yes ___ No ___ Never If so, how many packs a day:___for # years:___ # years quit?___

Do you drink alcohol? ___ Yes ___No If so, how often: _____

Do you have a history of drug or alcohol abuse? ____Yes ____No If yes, what? _____

Occupation (Status): _____ Date last worked: _____

Special Diet: _____

_____ _____ _____

Signature **Date** **Physician Initials**

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Patient Medical History: 2

Hospitalizations/Surgery History: Please indicate ANY hospitalizations or surgeries you have had in the past please include Date, Hospital and Procedure. If you cannot recall the exact date, then please give us the approximate time frame.

Date **Hospital** **Procedure**

_____

_____

_____

_____

_____

Please list ALL medications you are currently taking, please include Nutritional, or Herbal Substances.

Name **Dosage** **How Often**

_____

_____

_____

_____

_____

Please list any known allergies to medications, latex, foods, shellfish, tape products, or other substances.

Allergy	Reaction

Please list family history of diseases and include any diseases related to your current problem.

Member	Alive	Disease History (cause of death)
Grandmother: Mother	Yes/No	
Grandmother: Father	Yes/No	
Grandfather: Mother	Yes/No	
Grandfather: Father	Yes/No	
Mother	Yes/No	
Father	Yes/No	
Sister/Brother	Yes/No	
Sister/Brother	Yes/No	
Other		

_____ _____ _____

Patient Signature **Date** **Physician Initials**

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Review of Systems/Patient Medical History

First Name: _____M.I._____Last:_____DOB:_____

Musculoskeletal/Joints
- ☐ Muscular Disease
- ☐ Gout
- ☐ Arthritis
  - ○ Rheumatoid
  - ○ Degenerative
  - ○ SLE (Lupus)
  - ○ Fibromyalgia

Metabolic Problems
- ☐ Diabetes
- ☐ Thyroid ____ Hypo ____Hyper

Urinary Problems
- ☐ Urination Problems
- ☐ Prostate Disease
- ☐ Kidney Disease
- ☐ Kidney Failure
- ☐ Kidney Infection
- ☐ Kidney Stones

Cardiovascular Problems
- ☐ Angina
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Mitral Valve Prolapse
- ☐ Irregular Heartbeat ____Afib
- ☐ High Blood Pressure
- ☐ Shortness of Breath
- ☐ Pacemaker
- ☐ High Cholesterol

Gastrointestinal Problems
- ☐ Stomach Ulcers
- ☐ Gallbladder Problems
- ☐ Pancreatitis
- ☐ Colitis
- ☐ Blood in Stool
- ☐ Hiatal Hernia
- ☐ Liver Disease
- ☐ Constipation
- ☐ Reflux/GERD
- ☐ Loss of Bowel Control
- ☐ Hepatitis
  - ○ A
  - ○ B
  - ○ C
- ☐ Jaundice
- ☐ Diverticulitis

Immunological Diseases
- ☐ HIV Virus
- ☐ AIDS Virus

Neurological Problems
- ☐ Headaches
- ☐ Loss of Balance /Dizziness
- ☐ Migraines
- ☐ Seizures
- ☐ Epilepsy
- ☐ Strokes / TIA
- ☐ Depression
- ☐ Other:_____

Bleeding Disorders
- ☐ Anemia
- ☐ Blood Clots
- ☐ Bleeding Problems/Low Platelets

Respiratory Problems
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis

Reproductive System
- ☐ Infections
- ☐ Herpes/Venereal disease

Eyes
- ☐ Glaucoma
- ☐ Other:_____

Skin
- ☐ Psoriasis
- ☐ Other:_____

Cancer
- ☐ Lung
- ☐ Breast
- ☐ Colon/Intestinal
- ☐ Stomach
- ☐ Prostate
- ☐ Skin: Type _____
- ☐ Kidney
- ☐ Bone
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Other Malignancy: Type _____

WOMEN Only
- ☐ Endometriosis

Are you currently pregnant?
____Yes ____No

Are you currently trying to conceive?
____Yes ____No

_____ _____ _____

Patient Signature **Date** **Physician Initials**