VANDERBILT ORTHOPAEDIC INSTITUTE
THE VANDERBILT HAND CENTER
HAND AND UPPER EXTREMITY

New Patient Form

PATIENT NAME: ____________________
DATE OF BIRTH: ____________________
MEDICAL RECORD: __________________
DATE OF SERVICE: _________________
PHYSICIAN: ________________________

PLEASE PRINT

PHONE NO.: ___________________________
ADDRESS: _______________________________ CITY: ______________________ STATE: ________ ZIP: ______________
REFERRING PHYSICIAN: ____
ADDRESS: ___________________________ CITY: _______________ STATE: ________ZIP: ________ PHONE: ___________
FAMILY PHYSICIAN (NAME): _____________________________________ PHONE NO.: ___________________________
CHIEF COMPLAINT: ____ PAIN SCALE: 1 2 3 4 5 6 7 8 9 10
DATE OF INJURY: __________________ DOMINANT HAND: RIGHT LEFT INJURED HAND: RIGHT LEFT
Place of Employment: ________________________________ How Long: ____________
Type of Work: Sedentary Heavy Labor Occupation: ___________________________________
Present Work Status:____
Previous Work Comp Injuries: ____

OTHER ILLNESSES YOU NOW HAVE (IF ANY):
____
____
____

PRESENT WEIGHT: ________ HEIGHT: _______

PLEASE LIST ALL MEDICINES YOU ARE NOW TAKING:
____
____
____
____

PAST HISTORY- REVIEW OF SYMPTOMS (Circle Yes or No) If yes is NOT circled, response will be considered negative.
HAVE YOU EVER HAD or CURRENTLY EXPERIENCING:

Free Bleeding	Yes	No	Fainting Spells	Yes	No	Stomach Ulcers	Yes	No
Heart Trouble	Yes	No	Anemia (low Blood)	Yes	No	Kidney Trouble	Yes	No
Chest Pain	Yes	No	Numbness in Extremities	Yes	No	Varicose Veins	Yes	No
Irregular Heart Beat	Yes	No	Asthma	Yes	No	Leg Swelling	Yes	No
High Blood Pressure	Yes	No	Emphysema	Yes	No	Poor Circulation	Yes	No
Stroke	Yes	No	Anesthesia Problems	Yes	No	Diabetes	Yes	No
Paralysis	Yes	No	Spitting up Blood	Yes	No	Steroid Medication	Yes	No
Fever with Surgery	Yes	No	Thyroid Trouble	Yes	No	Blood Thinner Pills	Yes	No
Seizures	Yes	No	Back Ache (Severe)	Yes	No	Blood Clot in Legs	Yes	No
Ringing in Ears	Yes	No	Addiction Problems	Yes	No	Blood Clot in Lungs	Yes	No
Dizziness	Yes	No	Hepatitis	Yes	No	Blood Transfusion	Yes	No
Visual Changes	Yes	No	Jaundice	Yes	No	Cancer	Yes	No
Hypertension	Yes	No	Fever/Chills	Yes	No	Other: _________________________		

ARE YOU ALLERGIC TO:

Penicillin	Yes	No	Sulfa	Yes	No	"Mycin"	Yes	No
Aspirin	Yes	No	Codeine	Yes	No	Tetanus	Yes	No
Demerol	Yes	No	Other Medicine: Please List: ____					

FAMILY MEDICAL HISTORY — If yes is NOT circled, response will be considered negative.

HAS ANY BLOOD RELATIVE EVER HAD: WHO

			WHO				
Bone Disease	Yes	No	________________	Mental Illness	Yes	No	______________
Osteoporosis	Yes	No	________________	Arthritis	Yes	No	______________
Tuberculosis	Yes	No	________________	Congenital Deformities	Yes	No	______________
Diabetes	Yes	No	________________	Kidney Trouble	Yes	No	______________
Heart Trouble	Yes	No	________________	Anesthesia Problems	Yes	No	______________
High Blood Pressure	Yes	No	________________	Cancer	Yes	No	______________
Stroke	Yes	No	________________	Fever with Surgery	Yes	No	______________
Joint Contractures	Yes	No	________________	Bleeding Disorders	Yes	No	______________

SOCIAL HISTORY (Circle Yes or No) If yes is NOT checked, response will be considered negative.

DO YOU

Smoke or use other tobacco products Yes No If yes, how many packs per day ___________________

Drink alcoholic beverages Yes No If yes, average drinks per day _____________________

Please advise your physician of any cultural or spiritual issues that may affect you care:

Marital Status: Single Married Widowed Divorced Number of Children (if any):_______________

LIST ANY OPERATIONS HAD:

OPERATION	DATE	SURGEON	HOSPITAL

LIST ANY TESTING OR IMAGING THAT HAS BEEN DONE AND WHERE (EXAMPLE: EMG, NCV, MRI, X-RAYS)

____ ____

____ ____

____ ____

ADDITIONAL NOTES & COMMENTS:

PATIENT SIGNATURE: ____ DATE: ________________________

I HAVE REVIEWED THE INFORMATION PROVIDED ABOVE.

PHYSICIAN SIGNATURE: ____ DATE: ________________________