A R I Z O N A I N S T I T U T E F O R B O N E A N D J O I N T D I S O R D E R S

J O N J . H A N L O N , M . D .

O R T H O P E D I C S U R G E R Y O F T H E H A N D A N D U P P E R E X T R E M I T Y

PATIENT HISTORY

DATE:

NAME:

BIRTHDATE:

AGE:

SEX: ___**MALE** ___**FEMALE**

HEIGHT: **WEIGHT:**

Which Hand do you WRITE with? ___**RIGHT** ___**LEFT**

WHAT is the REASON that you are Seeing Dr. Hanlon Today?

HOW did the INJURY or PROBLEM Happen?

WHEN did the INJURY or PROBLEM Begin?

Who REFERRED you to Dr. Hanlon?

Have you ever HURT your Hand, Forearm, Elbow, or Arm Before? ___**Yes** ___**No**
What Was the Injury?

MEDICAL HISTORY:
What MEDICAL PROBLEMS are you Currently Being Treated For?

SURGICAL HISTORY:
Have You or Anyone in your Family had Problems with Anesthesia? ___**Yes** ___**No**
Please List All of the Surgeries that You Have Had:

ALLERGIES:
Please List **All** Medicines that you are Allergic to:

MEDICATIONS:
What MEDICATIONS Do You Take?

HABITS:
Do you Smoke tobacco? ___**Yes** ___**No** How Many Cigarettes per Day? ________________________
Do you drink Alcohol? ___**Yes** ___**No** How Much per Week? ________________________________

REVIEW OF SYSTEMS:
Head, Eyes, Ears, Nose, and Throat:
Do you have Dentures? (Full Partial Upper Lower) ___**Yes** ___**No**
Do you have Hearing Aids? ___**Yes** ___**No**
Have you had SEVERE Changes in Vision or Hearing? ___**Yes** ___**No**

Heart and Lungs:
Do you have High Blood Pressure? ___**Yes** ___**No**
Do you have Problems with Your Heart? ___**Yes** ___**No**

Have you EVER Had Problems with Your Heart? ___**Yes** ___**No**
Do you have Unusual Heart Beats (fast, slow, beating hard)? ___**Yes** ___**No**
Do you have Chest, Shoulder or Jaw Pain Now? ___**Yes** ___**No**
Do you have trouble Breathing at Night? ___**Yes** ___**No**
Do you have a frequent Cough, Wheeze, or Asthma? ___**Yes** ___**No**

Gastrointestinal:
Do you have Abdominal Pain, Indigestion, Heartburn or Ulcers? ___**Yes** ___**No**
Have you had Recent Changes in your Bowel Habits? ___**Yes** ___**No**
Do you have Hepatitis or Problems with your Liver? ___**Yes** ___**No**

Genitourinal:
Do have problems with Urination? ___**Yes** ___**No**
Do you have Blood in your Urine? ___**Yes** ___**No**
Do you have Bladder or Kidney Problems? ___**Yes** ___**No**

Neurologic:
Do you have Headaches Often? ___**Yes** ___**No**
Do you feel Dizzy or Faint Often? ___**Yes** ___**No**
Do you have Tremors? ___**Yes** ___**No**
Have you ever had Seizures? ___**Yes** ___**No**
Are you being treated for Depression or Anxiety? ___**Yes** ___**No**
Are you being treated for Mental Illness? ___**Yes** ___**No**

Skin:
Do have any Tattoos? ___**Yes** ___**No** If Yes, Where?
Do you Have Body Piercings? ___**Yes** ___**No** If Yes, Where?
Do you have any Skin Condition? ___**Yes** ___**No**

Musculoskeletal:
Do you have **Rheumatoid** Arthritis? ___**Yes** ___**No**
Do you have Osteoarthritis? ___**Yes** ___**No**
Do you have Back Pain or Stiffness? ___**Yes** ___**No**
Do you have Pain or Stiffness in you Hips or Knees? ___**Yes** ___**No**

Peripheral Vascular:
Do you Fingers or Toes become Numb and Blue/Black when exposed to cold temperature? ___**Yes** ___**No**
Do you have Varicose Veins or Problems with Circulation in your Legs? ___**Yes** ___**No**

Endocrine:
Do you have Diabetes? ___**Yes** ___**No**
Do you have Thyroid disease? ___**Yes** ___**No**
Have you had Recent Changes in Skin/Hair Texture? ___**Yes** ___**No**

Hemologic:
Have you Ever Had Blood Clots? ___**Yes** ___**No**
Do you have a History of Anemia? ___**Yes** ___**No**
Do you Bruise Easily? ___**Yes** ___**No**
Do you have any Blood Disorders? ___**Yes** ___**No**