PATIENT HEALTH HISTORY

Welcome to the Long Island Hand Center. In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. Thank you for your cooperation.

Patient's Last Name _____First _____ MI _____

Sex ☐ Male ☐ Female **Date of Birth: _____ Height: _____ Weight: _____**

Name of Primary Care Physician (include address):_____

Pharmacy Preference (include address): _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Medication/Vitamin/Herbal Supplement	Dosage and Frequency	Condition Treated

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ Yes ☐ No If yes, please list below:

Name of Medication	Type of Reaction

Do you have Sleep Apnea? ☐Yes ☐ No Are you using a CPAP Machine for this condition?☐ Yes ☐ No
Do you have a defibrillator?☐ Yes ☐ No
Is there any personal or family history of malignant hyperthermia/hypothermia?☐ Yes☐ No

SURGERIES AND HOSPITALIZATIONS:
List any surgeries you have had (including dates):

_____

_____

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐Yes ☐No
If yes, please list type of problems: _____

_____

Have you ever been hospitalized for non-surgical reasons? ☐Yes ☐ No
If yes, list reasons for hospitalizations _____

_____

List any past bone/joint injuries (i.e. fractures) (including dates):

_____

CURRENT OR MOST RECENT OCCUPATION: _____