JUPITER HAND TO SHOULDER

MEDICAL HISTORY FORM

Date:	
Patient Name:	**DOB:**
Medical Problem List:	
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.
Past Surgical History:	
Procedure:	Date (MM/DD/YY)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
Please use this space to list any complications from surgery:	
Allergies (please include nature of allergic reaction):	
Medication List (please include dose and frequency, and include all over the counter and supplements):	
1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.
Family History (if applicable, please include age deceased and cause of death):	
Mother	
Father	
Siblings	

PLEASE CONTINUE ON REVERSE SIDE OF PAGE

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Social History:					
Marital status:	☐Single	☐Married	☐Domestic	☐ Divorced	☐ Widowed
Children:					
Patient Name:				DOB:	
Tobacco Use:	☐ Yes. How much/day?		☐ No	☐Quit. How long ago?	
Alcohol Use:	☐ None	☐ Social	☐ Daily	☐ History of alcohol abuse?	

Review of Systems (please check all that apply):

General: ☐Fevers or chills ☐ Night sweats ☐ Loss of appetite ☐ Unintentional weight loss	Musculoskeletal: ☐ Generalized joint pain or swelling ☐ Weakness ☐ Soft tissue masses ☐ Musculoskeletal night pain
Ear, Nose, Throat: ☐Change in vision ☐Earache ☐Hearing loss ☐Sore throat ☐ Sinus congestion	Dermatologic: ☐ Rash ☐ Itching ☐ Lesions
Neck: ☐Pain ☐Stiffness ☐Masses	Endocrine: ☐ Excessive urination ☐ Excessive thirst ☐ Cold or heat intolerance ☐ Recent unexplained change in weight
Cardiovascular: ☐ Chest pain or pressure ☐Palpitations ☐Lightheadedness ☐Fainting spells	Hematologic: ☐ Anemia ☐ Easy bruising ☐ Bleeding ☐ Excessive clotting (DVT or PE)
Pulmonary: ☐ Shortness of breath ☐ Cough ☐ Wheeze	Neurologic: ☐ Headache ☐ Seizures ☐ Memory loss
Gastrointestinal: ☐Nausea ☐ Vomiting ☐Blood in stool ☐Change in bowel habits	Genitourinary: ☐Urinary frequency ☐Urgency ☐ Pain on urination
Psychiatric: ☐ Depression ☐ Anxiety ☐ Mood swings	☐ Loss of interest in normal activity ☐ Change in sleep pattern ☐ Hallucinations

I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature	Date

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