FORM
HAND, WRIST & ELBOW
INSTITUTE

39180 Farwell Drive
Fremont, CA 94538
phone: 510.857.1000
fax: 510.857.1001
www.drbesh.com

BASIL R. BESH, M.D.
Surgery of the Hand, Wrist & Elbow

CONFIDENTIAL MEDICAL HISTORY

Age: _____ Hand dominance: ☐ Left ☐ Right ☐ Ambidextrous Occupation: _____

Employer: _____ How long have you worked there? _____

Current work status: ☐ Full Duty ☐ Modified Duty ☐ Not Working ☐ Retired

Restrictions: _____ Date last worked: ____ / ____ / _____

Referred by: _____ Primary Care M.D: _____

What are you here to see the doctor for? _____

How did injury occur? _____

Is this work related? ☐ Y ☐ N Is this related to a car accident? ☐ Y ☐ N Date of injury: ____ / ____ / _____

Is this the date that the injury occurred, you first noticed symptoms, or you filed a claim?_____

When and what were the first symptoms? _____

How long have you had symptoms? _____ Whom have you seen for this condition? _____

Have you had similar problems in the past? (explain:) _____

STUDIES AND TREATMENT

Please check any studies you have had and include dates:

☐ X-RAY: _____
☐ MRI/CT Scan: _____
☐ EMG: _____
☐ OTHER: _____
_____

Please check any treatment you have had and include dates, duration, & number of visits:

☐ THERAPY: _____
☐ SPLINTS/BRACES: _____
☐ MEDICATIONS: _____
☐ INJECTIONS: _____
☐ OTHER: _____

DOCTOR'S NOTES:

MEDICAL HISTORY

MEDICAL CONDITIONS: To the best of your knowledge, have you ever had a serious medical problem related to the following?

Skin rashes or disorders	☐ Y ☐ N	Osteoporosis	☐ Y ☐ N	Ears, eyes, nose, or throat	☐ Y ☐ N
Bladder or kidneys	☐ Y ☐ N	Breasts	☐ Y ☐ N	Stomach, intestines	☐ Y ☐ N
Lung disease	☐ Y ☐ N	Epilepsy or stroke	☐ Y ☐ N	Heart disease	☐ Y ☐ N
Thyroid	☐ Y ☐ N	High blood pressure	☐ Y ☐ N	Diabetes	☐ Y ☐ N
HIV, Hepatitis	☐ Y ☐ N	Cancer	☐ Y ☐ N	Liver, gallbladder	☐ Y ☐ N
Blood disorders	☐ Y ☐ N	Kidney Disease	☐ Y ☐ N	Prostate/Bladder	☐ Y ☐ N

Explain all YES answers: _____

PAST SURGERIES:

Operation Surgeon Year Complications

_____

_____

_____

ALLERGIES : _____

_____

CURRENT MEDICATIONS: (PLEASE LIST ALL MEDICATIONS)

Name Dose\Frequency Reason

_____

_____

_____

_____

SOCIAL & PERSONAL HISTORY:

Do you smoke tobacco products? ☐ Y ☐ N (if YES, ___ packs per day for ___ years)

Are you an ex-smoker? ☐ Y ☐ N (if YES, ___ packs per day for ___ years)

How often do you drink alcohol? ☐ daily ☐ frequently ☐ occasionally ☐ never

Any history of substance abuse? ☐ Y ☐ N (if YES, please explain: _____)

What, if any, medical problems do your close relatives have? _____

Have you ever injured this body part before? ☐ Y ☐ N If so, how and when?_____

In what recreational activities do you enjoy participating?: _____

Review of Systems

CONSTITUTIONAL SYSTEMS

Appetite Change	☐ Y	☐ N
Chills	☐ Y	☐ N
Fever	☐ Y	☐ N
Headache	☐ Y	☐ N
Weight Loss	☐ Y	☐ N

CARDIOVASCULAR

Angina	☐ Y	☐ N
Arrhythmia	☐ Y	☐ N
Endocarditis	☐ Y	☐ N
Heart Attack	☐ Y	☐ N
Heart Valve Replacement	☐ Y	☐ N
High Blood Pressure	☐ Y	☐ N
Mitral Valve Prolapse	☐ Y	☐ N

RESPIRATORY

Asthma	☐ Y	☐ N
Chronic Cough	☐ Y	☐ N
Emphysema/Bronchitis	☐ Y	☐ N
Shortness of Breath	☐ Y	☐ N
Tuberculosis	☐ Y	☐ N

SKIN

Persistent Itching	☐ Y	☐ N
Unexplained Perspiration	☐ Y	☐ N
Rash	☐ Y	☐ N

NEUROLOGICAL

Dizziness	☐ Y	☐ N
Numbness	☐ Y	☐ N

GASTROINTESTINAL

Abdominal Pain	☐ Y	☐ N
Black Stools	☐ Y	☐ N
Heartburn	☐ Y	☐ N

ENDOCRINE

Excessive Thirst	☐ Y	☐ N
Too Hot/Cold	☐ Y	☐ N
Tired/Sluggish	☐ Y	☐ N

MUSCOSKELETAL

Arthritis	☐ Y	☐ N
Joint Pain	☐ Y	☐ N

PHARMACEUTICAL

Anti-inflammatories	☐ Y	☐ N
Aspirin Products	☐ Y	☐ N
Coumadin	☐ Y	☐ N
Glucophage	☐ Y	☐ N
Nitrates	☐ Y	☐ N
Persantine	☐ Y	☐ N
Plavix	☐ Y	☐ N

HEMATOLOGICAL

Bleeding Problem	☐ Y	☐ N
Blood Transfusion	☐ Y	☐ N
Hepatitis	☐ Y	☐ N
HIV (AIDS)	☐ Y	☐ N
IV Drug Use	☐ Y	☐ N
Swollen Glands	☐ Y	☐ N

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information or omitting information may be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status with each and every visit. I also authorize the health care staff to perform the necessary services I may need.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____

PRINTED NAME OR PATIENT OR RESPONSIBLE PARTY: _____

DATE: ____ / ____ / ____

For office use only: Height: ___'_____" Weight: _____ lbs. BMI: _____ BP: ____ /_____

PT NAME: _____