The Hand Center, P.C
Office of Kelley Wear, M.D.

www.HandCenterColorado.com
BROOMFIELD-THORNTON LOCATIONS

Phone: (303) 957-7116
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Medical History

Patient Name: ____________________ **Age:** _____ **Height:**_________ **Weight:**________

Is the Patient Right or Left handed?:_______ **Reason for Visit:** ____________________________________

Family History

Any history of illness/disease in your family? Yes No

If yes, please describe ____

____

Are your mother and father living? Yes No ____________________________________

Medications

List all drugs you are taking, including non-prescription, vitamins and herbals, with dosages:

____

____

____

Allergies

List all drugs, food, tape, latex, or anesthesia reactions, including post-operative nausea:

____

____

Personal History

Smoking (how much): ___________ **Alcohol or drugs (how much/often)** ______________

Hospitalization

List all hospitalizations, operations (including plastic surgery), and serious injuries, with the year:

____

____

Past Medical History

Have you ever had the following:

	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Glaucoma	☐	☐	Migraines	☐	☐
Angina	☐	☐	Heart disease	☐	☐	Nose bleeds	☐	☐
Arthritis	☐	☐	Heart murmur	☐	☐	Seizures	☐	☐
Asthma	☐	☐	Hepatitis _______	☐	☐	Sinus disease	☐	☐
Bladder infection	☐	☐	High Blood Pressure	☐	☐	Skin Cancer	☐	☐
Bleeding disorder	☐	☐	HIV +	☐	☐	Stroke	☐	☐
Cancer	☐	☐	Irritable bowel	☐	☐	Thyroid disease	☐	☐
Diabetes ________	☐	☐	Kidney disease	☐	☐	Ulcer	☐	☐
Emotional disorder	☐	☐	Lyme disease	☐	☐	Other: __________________		