The Milwaukee Hand Center
Medical History and Physical

Name _____ PMD _____

Date _____ RMD _____

We look forward to caring for your hand or upper extremity problem today. Thank you for taking a moment to share with us some background medical information on yourself. The doctor will refer to this information when examining you as well as when recommending treatment. Thank you for printing your responses. Please leave the top and bottom boxes empty.

Office Use:

My Medical Problems (Check any that apply)

___ **None**
___ Diabetes
___ High Blood Pressure
___ Heart Disease or Heart Attack
___ Atrial Fibbrilation
___ Seizures
___ Blood Clots
___ Stroke
___ Kidney disease
___ Liver problems or hepatitis
___ Bleeding Problems or Disorder
___ Asthma
___ Emphysema
___ Rheumatoid disease
___ Stomach ulcers or bleeding
___ Thyroid problems
___ Gout
___ Other _____
_____

Surgeries I have had

___ None ___ See Attached List

Year _____ Operation _____

Year _____ Operation _____

Year _____ Operation _____

Year _____ Operation _____

Year _____ Operation _____

My Current Medications

____ None ___ See Attached List

Drug _____ Dose _____ Drug _____ Dose _____

Drug _____ Dose _____ Drug _____ Dose _____

Drug _____ Dose _____ Drug _____ Dose _____

Medicines I am Allergic to

____ None

Drug_____Reaction_____ Drug_____Reaction_____

Drug_____Reaction_____ Drug_____Reaction_____

Office Use:

					Allen's		Tinels		PPT	
	Grip	Pinch	Wrist Flx	Wrist Ext	Radial	Ulnar	Median	Ulnar	Median	Ulnar
Right										
Left										