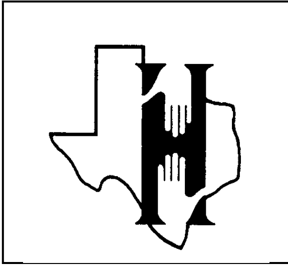

The Hand Center of San Antonio

Dr. David Green
Dr. David Person
Dr. Ramesh Srinivasan

Dr. Kunj Desai
Dr. James Saucedo
Dr. Mark Bagg

Whom may we thank for your referral?
DR. ____________________________
Phone ___________________________
Other____________________________
PCP_____________________________

Patient Information

Patient Name__________________________________ DOB____/____/_____ Age___________ Sex F M (circle)

Phone_____________________Cell______________________ SSN_____-_____-_____ Marital Status______________

Address____City_______________________State_______Zip__________

Employer Name____Phone_______________________________

Emergency Contact____Phone______________________________

EMAIL: ____ **Preferred Language:** ___________________________

Ethnicity: **Hispanic or Latino** **Other Student Status:** **Full Time** **Part Time**

Race: **American Indian or Alaska Native** **Asian** **Black or African American**

Native Hawaiian or Pacific Islander **White** **Other**

Primary Insurance Information

Primary Insurance Name____

Name of insured___________________________________ Phone______________________ DOB____/____/____

SSN______-________-________ Insurance ID Number ____________________Group Number______________

Address________________________________City________________________State__________Zip__________

Relationship to patient________________________

Secondary Insurance Information

Secondary Insurance Name____

Name of insured________________________________ Phone______________________ DOB____/_____/_____

SSN_____-_______-_______ Insurance ID Number _______________________Group Number________________

Address________________________________City________________________State__________Zip____________

Relationship to patient________________________

Work Related Information (for Worker's Compensation Injuries Only)

Employer_____________________________Phone__________________________Date of injury____________

Address_______________________________City_____________________State_________Zip_______________

___________________________ Reviewed by

__________________________ Date

__________________________ Patient #/ Doctor #

The Hand Center of San Antonio

Green | Bagg | Person | Srinivasan | Saucedo | Desai

21 Spurs Ln., Ste. 310 San Antonio, TX 78240

NEW PATIENT INTAKE

Name: ___________________________________ Age: ____ Male/Female (circle one) Date: _________

For Minor Children: Mother's Name _________________________ Father's Name ____________________

Are you: RIGHT-handed / LEFT-handed/ use BOTH equally? (In other words, what hand do you use more?)

What is your job or profession? ________________________________

Chief Complaint - Please briefly describe in your own words the problem that brings you into the office today.

HISTORY OF PRESENT ILLNESS

1. **When did this problem begin**: (date of injury or onset) _________________________________
2. **If you had an injury, how & where did it happen? What were you doing?** ___________________
   ____
3. **Problem is the result of** ____ Car Accident ____ Work Accident ____ Sport ____ Other
4. **Side of problem or injury** (please circle one): Right / Left/ Both sides
5. **Location of problem or inj**ury (please circle all that apply or use the space to explain):

   Shoulder / Elbow / Forearm / Wrist / Hand/ Thumb / ________ Finger / Other: __________________

6. **How would you describe your symptoms**: (please circle all that apply)
   Pain / Numbness / Tingling / Clicking / Popping / Locking / Stiffness /__________________________
7. **Quality of pain**: Sharp / Shooting / Stabbing / Electric / Dull / Throbbing / "Achy" / Other:__________
8. **Severity of pain** (0 = no pain, 10 = most intense pain you have ever experienced); please circle one:
   0 1 2 3 4 5 6 7 8 9 10
9. **Duration** (how long have you had symptoms?)____
10. **Frequency** (how often do you experience your symptoms?)
    Please answer both questions by circling what best describes you:
    a. "I experience these symptoms: Rarely / Sometimes / Off & On / Often / Constantly."
    b. "My symptoms occur mostly: In the morning / During the Day / At Night."
11. **Aggravating factors** (what makes it worse?)____
12. **What have you tried for it so far?** (please circle all that apply)
    Nothing / Rest / Stretching / Medication / Cream / Splint or Brace / Heat / Ice / Steroid Injections / Surgery
    Other: ____
13. **Alleviating factor** (what has made it better?)____
14. **Have you seen another physician or provider for this problem?** Yes / No

Where? ____ **When?** ______________________

What did they do for you?

____

15. **Do you have Legal Representation of related to your problem?** _____ Yes _____ No

Allergies

Do you have any allergies? ___ Yes ___ No If so, please list:

To **Medications**?

____

To **Foods**?

____

Are you allergic to latex? ___ Yes ___ No

Are you allergic to iodine? ___ Yes ___ No

Social History

Tobacco Use? (Required for all patients 13 years and older)

Types: Cigarettes Pipe Cigars Snuff Chew (Please circle)

__ Yes, I currently smoke. I smoke ____ packs per day and have smoked for ____ years.

__ No, but I used to smoke. I smoked ____ packs per day for ____ years and quit ___________.

__ No, I have never smoked

Alcohol Use

What kind? Wine Beer Liquor (Please circle)

Yes, ___ Rarely (1/month) ___ Occasionally (1-4/month) ___ Socially (1-2/week)

___ Frequently (3-5/week) ___ Daily

No, ___ Used to but stopped (date) ____________ ___ Never used alcohol

Do you use controlled or illegal substances?

Yes, ___ Rarely (<1/month) ___ Occasionally (1-4/month) ___ Socially (1-2/week)

___ Frequently (3-5/week) ___ Daily

No, ___ Used to but stopped (date) ____________ ___ Never used drugs

Which drugs do/did you use? (Please circle)

Amphetamines/Meth Anabolic Steriods Benzodiazepines Cocaine

Hallucinogens Marijana Opioids IV Inhaled Intranasal Oral

How often do you exercise?

___ Never ___ Rarely(<1/month) ___ Occasionally (1-4/month)

___ Frequently (3-5/week) ___ Daily

Do you have a Special Diet? ___ No Yes (describe) ______________________________

Medications

1. Are you taking any pain medications? ___ YES ___ NO If so, please list all OR attach a separate list:

Pain Medications	**Dose**	**Times per day**	**Reason for taking**
____________	________	__________	______________
____________	________	__________	______________
____________	________	__________	______________

2. **All other Medications** (Please include vitamins and supplements)

All other Medications	**Dose**	**Times per day**	**Reason for taking**
____________	________	__________	______________
____________	________	__________	______________
____________	________	__________	______________
____________	________	__________	______________
____________	________	__________	______________

3. **Pharmacy**. Please list your preferred pharmacy.
   Name:______________________________ Location: ______________________________
   Telephone # ______________________________

Past Medical History

1. **Have you or anyone in your immediate family ever had any of the following? (Check all that apply)**

Medical History	**Patient**	**Father**	**Mother**	**Brother**	**Sister**
No Medical Problems	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Back Pain	_____	_____	_____	_____	_____
Bleeding/Clotting Disorder	_____	_____	_____	_____	_____
Blood Transfusion	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Cardiovascular Disease	_____	_____	_____	_____	_____
Congestive Heart Failure	_____	_____	_____	_____	_____
COPD	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____
Diabetes Type 1	_____	_____	_____	_____	_____
Diabetes Type 2	_____	_____	_____	_____	_____
GERD	_____	_____	_____	_____	_____
Gastrointestinal Disorder	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____
GYN Problems	_____	_____	_____	_____	_____
Headaches	_____	_____	_____	_____	_____
Heart Attack	_____	_____	_____	_____	_____
Heart Murmur	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____

Medical History	Patient	Father	Mother	Brother	Sister
HIV	______	______	______	______	______
Hypertension	______	______	______	______	______
Insomnia	______	______	______	______	______
Kidney Disease	______	______	______	______	______
Lipid Disorder	______	______	______	______	______
Musculoskeletal	______	______	______	______	______
Osteoporosis	______	______	______	______	______
Positive PPD	______	______	______	______	______
Rheumatoid Arthritis	______	______	______	______	______
Seizures	______	______	______	______	______
Stroke	______	______	______	______	______
Substance Abuse	______	______	______	______	______
Thyroid Disorder	______	______	______	______	______
Tuberculosis	______	______	______	______	______
Other (please list below)	______	______	______	______	______

2. If you have or have had any other medical conditions not listed here, please specify.
____
____
____
____

Past Surgical History

1. Have you had any of the following (please check all that apply):

No Surgeries _____
Appendectomy _____
CABG _____
Elbow Surgery _____
Foot Surgery _____
Gall Bladder _____
Hand Surgery _____
Hernia Repair _____
Hip Surgery _____
Hysterectomy _____
Knee Surgery _____
Mastectomy _____
Neck Surgery _____
Shoulder Surgery _____
Spine Surgery _____
Tonsillectomy _____
Wrist Surgery _____
Other____________________________

2. Have you had any other surgeries for the current problem? ___ YES ___ NO

Surgeries for This Problem and if they helped?____

Surgeon ____ Year ____________

Review of Systems

Have you had or are you currently having problems with any of the following?

Please check all that apply and describe all CHECKED responses.

Systems	**Comments**
General	
Weight gain	___
Weight loss	___
Fatigue	___
Insomnia	___
Fever	___
Night-sweats/chills	___
Eye	
Glasses/contacts	___
Cataracts	___
Glaucoma	___
Ear/Nose/Throat	
Sinus trouble	___
Hearing loss	___
Ringing in ears	___
Heart	
Irregular heartbeat	___
High blood pressure	___
Chest pain	___
Fluttering in chest	___
Coronary disease	___
Lung	
Shortness of breath	___
Difficulty breathing	___
Lung disease	___
Persistent cough	___
Stomach	
Decreased appetite	___
Constipation	___
Heartburn	___
Nausea	___
Diarrhea	___
Hepatitis __A__B__C	___
Muscles	
Arthritis	___
Fractures	___
Sprains	___

Systems	Comments
Urinary Tract	
Kidney stone	___
Bladder/kidney infections	___
Prostate problems	___
Painful urinating	___
Skin	
Masses	___
Blisters	___
Non-healing wounds	___
Dermatitis	___
Neurology	
Seizures	___
Tingling	___
Numbness	___
Severe headaches	___
Mental Health	
Anxiety	___
Depression	___
Other (please describe)	___
Endocrine	
Increased thirst	___
Diabetes	___
Thyroid	___
Blood/Lymph	
Bleeding or clotting problems	___
Anemia	___
Swollen or enlarged lymph nodes	___
Immunological	
Hay fever	___
Lupus	___
HIV/AIDS	___

BP: _____/_____
HT: __________
WT: __________

I understand that any person who knowingly and with intent to defraud any insurance company or other persons, files a statement or claim containing any materially false information or who conceals, for the purpose of misleading, information concerning any fact, commits a fraudulent act, which is a crime subject to criminal prosecution and civil penalties.

____ ____________________
Signature of patient, parent or guardian (if minor) Date