

**PLEASE PRINT**

**RALEIGH HAND CENTER, P.A.  
INFORMATION & INSURANCE RECORD**

**DATE:** \_\_\_\_\_

**Patient Information:**

Full Name: Mr./Mrs./Ms/Dr. (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Sex: (circle) M F Social Security # \_\_\_\_\_

**Are you right or left handed? (CIRCLE ONE)**

Marital Status: (circle) \_\_\_\_\_ Child \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address if different from above: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Mobile/Beeper: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**Occupation** \_\_\_\_\_

Work Status (circle): Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Unemployed \_\_\_\_\_ Self-employed \_\_\_\_\_ Student \_\_\_\_\_ Retired \_\_\_\_\_ Disabled \_\_\_\_\_

**Full name of physician** who referred you: **Full** Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**Full name** of primary care physician: **Full** Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**PLEASE GIVE A BRIEF DESCRIPTION OF YOUR PROBLEM:**

**DATE SYMPTOMS STARTED:**

Is your problem related to an accident? Yes No Type of accident: Job Motor Vehicle Other  
=====

**Do you have any of the following?**  Diabetes  High Blood Pressure  Heart problems  Gout  
 Asthma/COPD  Stomach ulcers  Arthritis  Thyroid Disease

Have you experienced any of the following in the last 3 months? (Please check)

- Weight loss  Fever/chills  Fatigue  Joint Pain  Joint or limb swelling
- Numbness  Hepatitis  HIV  Skin rashes  Nausea/Vomiting
- Diarrhea  Chest pain  Shortness of breath  Depression  Seasonal allergies

Please list all other medical conditions: \_\_\_\_\_

Please list past surgeries/operations: \_\_\_\_\_

**Current medications**  No  Yes **If yes please list:** \_\_\_\_\_

**Any drug allergies**  No  Yes **If yes please list:** \_\_\_\_\_

Social History: Tobacco? YES NO Amount \_\_\_\_\_ per \_\_\_\_\_

Alcohol? YES NO Amount \_\_\_\_\_ per \_\_\_\_\_

Hobbies: \_\_\_\_\_

Family History: Has anyone in your immediate family (Mother, Father, Siblings, Children) had any of the following? (Please check & identify which family member)

Arthritis: \_\_\_\_\_ Diabetes: \_\_\_\_\_ High Blood Pressure: \_\_\_\_\_

Cancer (type): \_\_\_\_\_ Heart Disease: \_\_\_\_\_

*All items on this page were reviewed by \_\_\_\_\_ (MD initials) on the date of patient's first examination.*

