



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 # _____



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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 injury** (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? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please list: To Medications? _____ To Foods? _____
Are you allergic to latex? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you allergic to iodine? <input type="checkbox"/> Yes <input type="checkbox"/> No

Social History

Tobacco Use? (Required for all patients 13 years and older) Types: Cigarettes Pipe Cigars Snuff Chew (Please circle) <input type="checkbox"/> Yes, I currently smoke. I smoke _____ packs per day and have smoked for _____ years. <input type="checkbox"/> No, but I used to smoke. I smoked _____ packs per day for _____ years and quit _____. <input type="checkbox"/> No, I have never smoked
--

Alcohol Use

What kind? Wine Beer Liquor (Please circle) Yes, <input type="checkbox"/> Rarely (1/month) <input type="checkbox"/> Occasionally (1-4/month) <input type="checkbox"/> Socially (1-2/week) <input type="checkbox"/> Frequently (3-5/week) <input type="checkbox"/> Daily No, <input type="checkbox"/> Used to but stopped (date) _____ <input type="checkbox"/> Never used alcohol

Do you use controlled or illegal substances?

Yes, <input type="checkbox"/> Rarely (<1/month) <input type="checkbox"/> Occasionally (1-4/month) <input type="checkbox"/> Socially (1-2/week) <input type="checkbox"/> Frequently (3-5/week) <input type="checkbox"/> Daily No, <input type="checkbox"/> Used to but stopped (date) _____ <input type="checkbox"/> Never used drugs
Which drugs do/did you use? (Please circle) Amphetamines/Meth Anabolic Steroids Benzodiazepines Cocaine Hallucinogens Marijuana 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** Dose Times per day Reason for taking
(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