SAN DIEGO HAND SURGERY
6610 Flanders Drive, Suite 101, San Diego, CA 92121
Tel: 858.795-8866 Fax: 888.369.3692
Email: sandiegohand@gmail.com

Please fill out this form **completely** Date: _____

Patient Name: _____ Age: _____ Birth Date: _____

Address_____

City_____ State _____ Zip _____

Social Security #*: _____ E-mail:_____

Cell Phone*: _____ Home Phone: _____ Work Phone: _____

Occupation*: _____ Employer: _____

Which phone number may we call/leave a detailed message on? Home☐ Work☐ Cell☐

Spouse Name or Parent: _____

Marital Status: ☐Single ☐ Married ☐Divorced ☐Widow ☐Separated

Referred by* _____ Date of Injury/Accident: _____

MEDICAL HISTORY

Height: _____ft _____in Weight: _____ lbs Pregnant? YES ☐ NO ☐

Date of last physical exam? _____ Doctor: _____ Clinic: _____

Medical Problems? (Please circle)

Arthritis	Diabetes	Lung Disease	Migraine Headaches
Asthma	High Blood Pressure	Liver Disease	Peptic Ulcer
Stroke	Heart Disease	Kidney Disease	Cancer
Connective Tissue Disorder		Other (Please specify) _____	

Please list PREVIOUS Surgeries: _____

Are you subject to excessive bleeding when cut? YES ☐ NO ☐

Taking any medications (including recreational drugs)? _____

_____

Are you allergic to any medications? YES ☐ NO☐
Do you smoke*? YES ☐ NO ☐ How much? _____
Are you under the care of a psychiatrist? YES ☐ NO ☐
Number of pregnancies? _____ Number of births? _____

Family history of any medical problems? _____

WORKER'S COMPENSATION ONLY	
Name of Insurance carrier	
Claim Number	
Adjuster's Name and Phone Number	
Adjuster's Fax	