MIDWEST HAND AND WRIST SURGERY DR. DHAWAN
Caring for the Hands that Care for Others

314-500-5888 / 618-500-5888
314-451-8885
mhwsurgery.com
info@mhwsurgery.com
157 Chesterfield Business Parkway,
Chesterfield, MO 63005

MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____/_____/_____
Reason for Today's visit?_____
Who referred you to our office? _____

Do you have or have you ever had any of the following relating to the hands, fingers, arms or shoulders:
Right or Left Hand Dominant? (Please circle one)
Numbness? ☐ YES ☐ NO Lumps/Bumps/Masses? ☐ YES ☐ NO Injuries/Falls? ☐ YES ☐ NO
Do you use a keyboard or mouse often? ☐ YES ☐ NO Stiffness? ☐ YES ☐ NO
Difficulty doing daily activities? ☐ YES ☐ NO If yes, which activities_____

Women: Are you?
Pregnant/Trying to get pregnant? ☐ YES ☐ NO Taking oral contraceptives? ☐ YES ☐ NO
Nursing? ☐ YES ☐ NO

Social History:
Do you use tobacco or tobacco products? ☐ YES ☐ NO How much?_____
Do you drink alcohol? ☐ YES ☐ NO How much?_____ How often?_____
Do you use controlled substances? ☐ YES ☐ NO

Allergies:
☐ None ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Latex
☐ Sulfa Drugs ☐ Other _____
If yes, please explain (reaction): _____

Medications:

Medication	Dosage	Purpose	Frequency

Do you take any of the following medications?
Coumadin (Warfarin)? ☐ Yes ☐ No **Aspirin?** ☐ Yes ☐ No 81mg/325mg?
Plavix? ☐ Yes ☐ No **Eliquis?** ☐ Yes ☐ No **Metformin?** ☐ Yes ☐ No

Surgical history:
List previous orthopaedic surgeries with dates:_____
_____
_____
List previous non-orthopaedic surgeries with dates:_____
_____

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Do you use a CPAP machine? ☐ Yes ☐ No Do you use home oxygen? ☐ Yes ☐ No

Do you use a cane or a walker? ☐ Yes ☐ No if yes, what hand?_____

Do you have or have you had any of the following?

ADHD	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	DVT	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Alzheimer's	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraines	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Peripheral Neuropathy	☐ Yes ☐ No
Angina(Chest pain)	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Heart Defibrillator	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Raynaud's Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Reflux	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Schizophrenia	☐ Yes ☐ No
Bipolar	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Blood clots	☐ Yes ☐ No	IBS	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
BloodTransfusion	☐ Yes ☐ No	Indigestion	☐ Yes ☐ No	Sleep apnea	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Irregular heartbeat	☐ Yes ☐ No	Stents	☐ Yes ☐ No
COPD	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Crohn's Disease	☐ Yes ☐ No	Kidney Stones	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Dementia	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Lupus	☐ Yes ☐ No	Weakness	☐ Yes ☐ No

Do you have any other serious illness NOT listed above?