Avery Arora, MD
Surgery of the Hand, Wrist, Elbow
arorahandsurgery.com

Patient Information

Patient's Name: ____

Social Security ________________________________ Birth date: ______________________________

Sex: Male Female

Street Address: ____ Apt/Unit:

City: _________________________________ State:_______________________Zip:________________

Home Phone: _____________________Cell: _____________________ Work: ______________________

Email address: ____

Retired: YES **NO** Current/Former Occupation ____

Is there a lawyer involved in the problem you are being seen for today? YES NO

Emergency Contact Name: ____

Relationship: ____

Home Phone:_______________________Cell:_____________________Work:_____________________

Do you have an advance directive? YES NO

If yes, Name: ____

Relationship: ____

How did you find Dr. Arora?

Prior patient Internet search Another Doctor Other

Current Doctors

Primary Care Physician

Dr.____________________________________ Phone:____

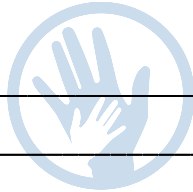
City:___________________________________ Fax:____

Referring Physician (if any)

Dr.____________________________________ Phone:____

City:___________________________________ Fax:____

Other Important Doctors:



Avery Arora, MD
Surgery of the Hand, Wrist, Elbow

Dr.____________________________________ Phone:____

City:___________________________________ Fax:____

Specialty:____

PHARMACY INFORMATION

Pharmacy: ____

Phone:_______________________________________ Fax:____

Address (or cross roads):____

City:____State:_________________Zip:________________

Medications

Please list all current medications and dosage

(1)____ Dose:____

(2)____ Dose:____

(3)____ Dose:____

(4)____ Dose:____

(5)____ Dose:____

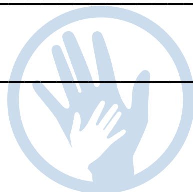
(6)____ Dose:____

(7)____ Dose:____

(8)____ Dose:____

(9)____ Dose:____

(10)____ Dose:____



Avery Arora, MD
Surgery of the Hand, Wrist, Elbow

Medical History

Check all that pertains to you:

☐ **I have no medical history**

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation
☐ Cancer
Type:_________________
☐ Diabetes: Type 1 or 2
☐ COPD

☐ Fibromyalgia
☐ Gout
☐ Heart Disease
☐ Hepatitis C
☐ High Blood pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Kidney disease

☐ Lupus
☐ Psoriasis
☐ Rheumatoid Arthritis
☐ Stroke
☐ OTHER:
____
☐ _______________________
☐ _______________________

Allergies

I have allergies to medications: YES NO

If yes, please list:

Medication:____Reaction:_________________________________

Medication:____Reaction:_________________________________

Medication:____Reaction:_________________________________

Medication:____Reaction:_________________________________

Medication:____Reaction:_________________________________

Medication:____Reaction:_________________________________

Medication:____Reaction:_________________________________

Do you have a Latex Allergy? YES NO

Are you allergic to Nickel? YES NO

Avery Arora, MD
Surgery of the Hand, Wrist, Elbow

Surgical History

Check all that pertains to you:

☐ **I have no surgical history**

TYPE	YEAR
____	________________
____	________________
____	________________
____	________________
____	________________
____	________________
____	________________
____	________________

Have you been hospitalized in the last 5 years**?** **YES** **NO**

If yes, why? ____

Family History

Father: Alive Deceased

Mother: Alive Deceased

Please indicate if your mother / father have/had a history of:

- Diabetes? **YES** **NO** If yes, who ______________________________
- High blood pressure? **YES** **NO** If yes, who______________________________
- Heart disease? **YES** **NO** If yes, who ______________________________
- Stroke? **YES** **NO** If yes, who ______________________________
- Cancer? **YES** **NO** If yes, who and what type ________________

Social History

Avery Arora, MD
Surgery of the Hand, Wrist, Elbow

Marital Status: Single Domestic Partner Married Widowed Separated Divorced

Smoking: Current smoker Former Smoker Non-Smoker

If a current smoker, how many cigarettes per day? 5 or less 6-10 11-20 21-30 31+

Are you interested in quitting? **YES** **NO**

If you are a former smoker, how long since you last smoked? ____

How much did you smoke? ____

Alcohol: Do you drink alcohol? **YES** **NO**

If yes, how often did you drink in the past year?

Socially/Occasionally Monthly Weekly Daily

How many drinks do you consume when you do drink? 1-2 3-4 5 or more

Drugs: Have you ever used illegal/"street" drugs *in the past year*? **YES** **NO**

If yes, please list: ____

Review of Systems

Please mark an answer for each

CARDIOVASCULAR

Heart murmur	YES	NO
Heart disease	YES	NO
Irregular heart rate	YES	NO

RESPIRATORY

Shortness of breath	YES	NO
Cough	YES	NO
Wheezing	YES	NO

GASTROINTESTINAL

Nausea/vomiting	YES	NO
Abdominal pain	YES	NO
Heartburn/reflux	YES	NO

CONSTITUTIONAL

Recent weight change	YES	NO
Night sweats/fever	YES	NO
Fatigue	YES	NO

MUSCULOSKELETAL

Muscle pain/cramps	YES	NO
Stiffness	YES	NO
Joints swelling	YES	NO

ENDOCRINE

Diabetes	YES	NO
Excessive thirst	YES	NO
Excessive urination	YES	NO

NEUROLOGICAL

Frequent headaches	YES	NO
Convulsions/seizures	YES	NO
Numbness/tingling	YES	NO

EYES

Glasses/Contacts	YES	NO
Blurred/Double Vision	YES	NO

INTEGUMENTARY (Skin)

Rashes/itching	YES	NO

EARS/NOSE/THROAT/MOUTH

Hearing loss/ringing	YES	NO
Sinus problems	YES	NO
Nose bleeds	YES	NO
Voice change	YES	NO

ALLERGIC/IMMUNOLOGIC

Seasonal allergies	YES	NO
Immune deficiency	YES	NO

HEMATOLOGIC/LYMPHATIC

Bruise easily	YES	NO
History of blood clot	YES	NO
Bleeding disorders	YES	NO

PSYCHIATRIC

Insomnia	YES	NO
Confusion	YES	NO
Memory loss	YES	NO

MALE ONLY – GENITOURINARY

Blood in urine	YES	NO
Kidney Stones	YES	NO
Testicular pain	YES	NO

FEMALE ONLY – GENITOURINARY

Blood in urine	YES	NO
Kidney Stones	YES	NO
Menstrual problems	YES	NO
Pregnant	YES	NO

Avery Arora, MD
Surgery of the Hand, Wrist, Elbow

Weight: ____________ **Height:** _____________

Current Pain Level:

Please mark below on scale from 0 – 10