



Dean D. Worthingstun ~ Blue Ridge GA 30513

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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: M / F Preferred Language: \_\_\_\_\_ Ethnic Group: \_\_\_\_\_ Race: \_\_\_\_\_

Emergency Contact (name): \_\_\_\_\_ Phone number: \_\_\_\_\_

Phone Number: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City / State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Physical Street Address: \_\_\_\_\_

City / State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Occupation / Place of Employment: \_\_\_\_\_

Release of Protected Health Information: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Preferred Pharmacy** \_\_\_\_\_

(Primary - default)

(Secondary - if applicable)

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

City or Zip Code: \_\_\_\_\_

City or Zip Code: \_\_\_\_\_

**Primary Care Provider:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_



# GEORGIA FOOTHILLS Hand Surgery

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## Past Medical History

Select any of the following medical conditions you currently have:

Name: \_\_\_\_\_

- |   |   |
|---|---|
| <input type="radio"/> NONE  | <input type="radio"/> Hypercholesterolemia  |
| <input type="radio"/> Anxiety Disorder                              | <input type="radio"/> Hyperthyroidism   |
| <input type="radio"/> Asthma  | <input type="radio"/> Hypothyroidism  |
| <input type="radio"/> Atrial Fibrillation (Irregular heartbeat)     | <input type="radio"/> Ischemic Heart Disease  |
| <input type="radio"/> Benign Prostatic Hyperplasia                  | <input type="radio"/> Left-handed   |
| <input type="radio"/> Bipolar Disorder                              | <input type="radio"/> Leukemia  |
| <input type="radio"/> Blood Clot (DVT)                              | <input type="radio"/> Malignant Lymphoma  |
| <input type="radio"/> Cerebrovascular Accident (stroke)             | <input type="radio"/> Malignant Tumor of Lung   |
| <input type="radio"/> Chronic Anemia                                | <input type="radio"/> Malignant Tumor of Breast   |
| <input type="radio"/> COPD  | <input type="radio"/> Malignant Tumor of Colon  |
| <input type="radio"/> Chronic Pain                                  | <input type="radio"/> Malignant Tumor of Prostate   |
| <input type="radio"/> Coronary Arteriosclerosis                     | <input type="radio"/> Morbid Obesity  |
| <input type="radio"/> Depressive Disorder/Depression                | <input type="radio"/> Multiple Myeloma  |
| <input type="radio"/> Diabetic on Insulin                           | <input type="radio"/> Obesity   |
| <input type="radio"/> Disease caused by 2019-nCoV                   | <input type="radio"/> Primary Fibromyalgia Syndrome   |
| <input type="radio"/> End Stage Renal Disease                       | <input type="radio"/> Pulmonary Embolism  |
| <input type="radio"/> Epilepsy                                      | <input type="radio"/> Pulmonary Hypertension due to Diastolic Systemic Ventricular<br>Dysfunction |
| <input type="radio"/> Gastroesophageal Reflux Disease               | <input type="radio"/> Right-handed  |
| <input type="radio"/> History of Hypertension (high blood pressure) | <input type="radio"/> Type 2 Diabetes (non insulin)   |
| <input type="radio"/> HX of Prim. Hyperparathyroidism               | <input type="radio"/> Other   |
| <input type="radio"/> HX of Radiation therapy                       | _____   |
| <input type="radio"/> HIV   |   |



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## Past Surgical History

Have you had any surgeries on the following organs?

- NONE
- Bypass of Stomach (Gastric Bypass)
- Coronary Artery Bypass graft
- Diverticulitis (Colectomy)
- Entire Transplanted Kidney
- Excision of Basal Cell Carcinoma
- Excision of Melanoma
- Excision of Squamous Cell Carcinoma
- H/O Colostomy
- H/O Tubal Ligation
- History of Appendectomy (Appendix)
- History of Cholecystectomy (Gallbladder)
- History of Colectomy (Diverticulitis)
- History of Liver Excision

- History of Mastectomy (Breast)

**SPECIFY:** *Right Left Both*

- History of Angioplasty
- Lumpectomy of Breast
- Mechanical Heart Valve Replacement
- Pancreas: Pancreatectomy
- Prostate (Prostatectomy) Prostate Cancer
- Total Hysterectomy

Notes: \_\_\_\_\_

- Transplantation of Heart
- Transplantation of Liver

Other \_\_\_\_\_

## Musculoskeletal Disease History

Have you had any of the following?

- NONE
- Adhesive Capsulitis of Shoulder
- Ankylosing Spondylitis
- Bursitis
- Notes: \_\_\_\_\_
- Carpal Tunnel Syndrome
- Notes: \_\_\_\_\_
- Chronic Low Back Pain
- Notes: \_\_\_\_\_
- Complex Regional Pain Syndrome
- Compression Fracture of Vertebral Column
- Epidural Steroid Injections
- Fracture at Wrist and/or Hand Level
- Fracture of Ankle
- Notes: \_\_\_\_\_

- Fracture of Vertebral Column
- H/O Hip Fracture
- Osteoarthritis
- Osteopenia
- Osteoporosis
- Primary Gout

Notes: \_\_\_\_\_

- Psoriasis with Arthropathy
- Rheumatoid Arthritis
- Sarcoma of Bone
- Sciatica
- Secondary Malignant Neoplasm of Bone
- Spinal Stenosis in Cervical Region
- Spinal Stenosis of Lumbar Region
- Vitamin D Deficiency



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## Musculoskeletal Surgical History

Have you had any of the following?

- NONE
- Arthroplasty of Knee
- Arthroplasty of Shoulder
- Arthroplasty of the Carpometacarpal  
Joint of the Thumb (CMC)
- Arthroscopy of Knee
- Arthroscopy of Shoulder
- Cervical Arthrodesis
- Complete Repair of Rotator Cuff

- Decompression of Median Nerve  
Carpal Tunnel Release  
**SPECIFY:** *Right Left Both*
- Excision of Bunion
- Excision of Ganglion Cyst
- Lumbar Spinal Fusion
- Release of Trigger Finger

Notes:

\_\_\_\_\_

- Repair of Ankle
- Repair of Meniscus
- Total Knee Replacement
- Total Replacement of Hip
- Total Shoulder Replacement

Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Musculoskeletal Family History

Is there a history of any of the following? (\*Immediate family)

- NONE
- Diabetes
- Notes: \_\_\_\_\_
- Hypertension

- Osteoarthritis
- Osteoporosis
- Scoliosis

Other \_\_\_\_\_

## Social History

**Smoking Status (please choose one):**

- Current every day smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked
- Illicit Drug Use

**Alcohol Intake (please choose one):**

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day

How many times in the past year have you had more than 4 drinks in  
a day? \_\_\_\_\_

Pneumonia Vaccination: Yes / No

Advance Directive: Yes / No

Living Will: Yes / No

