



Patient Registration Form

Date: _____

Name of patient (please print): _____ DOB: _____

Patient's address: _____

Street City State Zip code

Home phone: () _____ Cell phone: () _____

Driver's license #: _____ Social Security #: _____

Marital status: Single Married Widowed Divorced Separated Sex: M / F

Occupation: _____ Employer name: _____

Employer address: _____

Street City State Zip code phone

Spouse's name: _____ DOB: _____ SS#: _____

Spouse's employer: _____ Work phone: _____

If patient is a minor, responsible adult: _____

Address (if different) _____ phone: _____

Social Security no: _____ DOB: _____ relation: _____

What is your present complaint? _____

Date of injury? _____ Related to: Auto Work Other _____

Emergency contact: _____ relation: _____

Address: _____ phone: _____

How did you hear about us? _____

Primary insurance information: _____

Name policy/group I.D. #

I hereby authorize Eric L. Freedman, M.D. to furnish the above insurance company all information which said insurance company may request concerning my illness or injury. I hereby assign to Eric L. Freedman M.D. all payments to which I am entitled for medical and/or surgical expense relative to the services reported for the above. I understand I am financially responsible to said doctors for my portion of allowed charges, charges applied to my deductible or charges not covered by my policy. If monthly payments become past due, I agree to pay the total amount owing upon demand and to pay reasonable service charges, collection cost, attorney fees, and court cost as permitted by law. I understand I will be charged a \$15.00 service fee for any returned checks.

Date

Patient or legal guardian



General Health Questionnaire

Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____ RT or LT Handed?

List all current treating physicians: _____

Chief Complaint: List the medical problem(s) which have lead you to seek medical help today, and a brief history on how it began:

Do you have any allergies?: Y / N If yes, what are they?: _____

List all current medications (include herbs/supplements/vitamins):

- | | |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

Do you have any illnesses/medical problems/health conditions?:

Heart problems/diabetes/elevated cholesterol/high blood pressure

Other: _____

List all previous surgeries/procedures and dates:

Do any conditions run in your family? (Circle or write in)

Diabetes/cancer/leukemia/tuberculosis/heart trouble/high blood pressure/stroke/anemia/bleeding tendency/kidney disease/ _____

Are you (circle one): Married Single Widowed Divorced Significant other



DESERT HAND ASSOCIATES
SURGERY OF THE HAND AND UPPER EXTREMITY

ERIC L. FREEDMAN, M.D.

How many children do you have? _____

Are you employed? Y / N Full time or Part time

What is your occupation? _____

If you are not employed, when did you last work? _____

Are you disabled? Y / N Did you retired? Y / N when? _____

Do you drink alcohol? Y / N Quantity: _____

Are you a smoker? Y / N How long? _____ Packs per day: _____

Were you previously a smoker? Y / N How long ago? _____

Review of systems

Do you or have you ever had any of the following problems?:

Skin:

Skin infections or boils? _____	Y / N
Sores that do not heal? _____	Y / N
Change in skin moles? _____	Y / N

Head:

Recent severe headaches? _____	Y / N
Blackout or fainting spells? _____	Y / N
Convulsions or epilepsy? _____	Y / N

Eye, Ear, Nose, and Throat:

Difficulty or pain with swallowing? _____	Y / N
Glaucoma? _____	Y / N
Ear infections? _____	Y / N
Trouble with balance? _____	Y / N

Breast: (both women and men)

Do you have a lump or tumor now? _____	Y / N
Have you ever had discharge from a nipple? _____	Y / N

Heart and Lungs:

Does shortness of breath limit mobility? _____	Y / N
Frequent cough? _____	Y / N
Emphysema? _____	Y / N
Chest pain or discomfort? _____	Y / N
Leg cramps at night? _____	Y / N
Leg aches when walking? _____	Y / N
Tuberculosis? _____	Y / N
Pneumonia? _____	Y / N
Coughing up of blood? _____	Y / N
Heart attack or coronary problems? _____	Y / N
Do you prop yourself up to sleep? _____	Y / N
Angina? _____	Y / N



DESERT HAND ASSOCIATES
SURGERY OF THE HAND AND UPPER EXTREMITY

ERIC L. FREEDMAN, M.D.

Blood clots?	_____	Y / N
Abnormal EKG?	_____	Y / N
Heart murmur?	_____	Y / N
High blood pressure?	_____	Y / N
Varicose veins on legs?	_____	Y / N
Swollen ankles?	_____	Y / N
Inflamed veins (thombophlebitis)?	_____	Y / N
Stomach and bowels:		
Pain, indigestion or heartburn?	_____	Y / N
Cramps in the stomach or abdomen?	_____	Y / N
Bloody or black bowel movements?	_____	Y / N
Are you currently taking iron?	_____	Y / N
Frequent loose stool or diarrhea?	_____	Y / N
Recent change in bowel habits?	_____	Y / N
Stomach, duodenal or peptic ulcer?	_____	Y / N
Hepatitis or cirrhosis?	_____	Y / N
Kidney and Bladder:		
Do you get up often at night to urinate?	_____	Y / N
Has urination been painful recently?	_____	Y / N
Have you ever had a kidney infection?	_____	Y / N
Do you lose control of your bladder?	_____	Y / N
Have you ever had kidney stones?	_____	Y / N
Glands:		
Sugar diabetes?	_____	Y / N
Sugar in urine or blood?	_____	Y / N
A thyroid disorder?	_____	Y / N
Other glandular problems?	_____	Y / N
Blood:		
Swollen glands in armpits, neck or groin?	_____	Y / N
Excessive bleeding with operations?	_____	Y / N
A diagnosis of 'bleeder'?	_____	Y / N
A diagnosis of anemia?	_____	Y / N
Nervous System:		
Ever hand numbness of your arms or legs?	_____	Y / N
Ever lost control of your hands or legs?	_____	Y / N
Ever had a stroke or paralysis?	_____	Y / N
Often been tense / nervous / depressed or worried?	_____	Y / N
Been treated for emotional problems?	_____	Y / N
Muscles and Bone:		
Recent severe back pain?	_____	Y / N
Arthritis?	_____	Y / N
A bone infection (osteomyelitis)?	_____	Y / N
Recent joint swelling or pain?	_____	Y / N
A broken bone?	_____	Y / N
Gout?	_____	Y / N

Do you have any other problems that have not already been mentioned? If so, please specify:

FOR OFFICE USE ONLY

RT -

Grips and pinches: LT -

Eric L. Freedman, M.D. _____ Date