

COLORADO HAND THERAPY, LLC
HEALTH HISTORY QUESTIONNAIRE

Name (Last, First, .I.):

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed or surgeries that you have had

Allergies to medications: Yes No

Name the Drug	Reaction You Had

Are you allergic to:

Latex: Yes No

Iodine: Yes No

Any other allergies? Please list

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

HEALTH HABITS

Caffeine None Coffee Tea Cola

Tobacco Do you use tobacco? Yes No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Heart Related Problems	<input type="checkbox"/> Bone Joint Disease	
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Arthritis – Rheumatism/Osteo	<input type="checkbox"/> Energy level
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV Positive/AIDS	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Any Blood Disorder	

Briefly Explain:

Are there other healthcare professionals who are following your care for this accident or injury (M.D.'s, therapists, case manager)?

Name:	Phone #:
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Name:	Phone #:
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Name:	Phone #:
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