Georgia Foothills Hand Surgery
980 East Main Street, Suite 300
Blue Ridge, GA 30513
Tel: 706-946-7300 Fax: 706-946-7305 Cell: 678-628-8565
Web: www.georgiafoothillshandsurgery.com

NEW PROBLEM QUESTIONNAIRE

Today's Date: _____

Patient Name: _____ Name you prefer to be called: _____

DOB: ____/____/____ Age Today: _____ Occupation: _____

Dominant Hand: RIGHT___ LEFT____ Primary Care Physician _____

Date of injury or first onset of problem: ____/____/____ Right, left or both affected: _____ Pregnant? ____

Please describe symptoms & injury: _____

_____

_____

Is This Work Related: YES____ NO_____

If YES:
1. Date of Injury: _____/_____/_____
2. Date Last Worked: _____/_____/_____
3. Describe your job functions: _____
4. Company Name: _____
5. How long have you worked here? _____
6. How long have you worked in this position? _____
7. Describe any work restrictions: _____

Treatments Used:	Y	N		Y	N
Anti-Inflammatory Meds			Cortisone Injection		
Therapy			Cortisone Pills		
Brace, Splint, Cast (Please circle item used)			Chiropractic		
Ice			Heat		
Other:			Other:		

Test and/or Studies that you have had performed: (Please list Date and Location)

X-Rays		NCS/EMG	
MRI		Bone Scan	
Lab Work		Other	

Height: _____ Feet _____ Inches Weight: _____ lbs

Do You Have Allergies to Medication: Yes____ No____ (If Yes, List Below) □ Latex Allergy

1. _____ 2. _____ 3. _____ 4. _____

Patient Name: _____

Current Medications: (Name, Dosage, Frequency)

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

Past Medical History:	Y	N		Y	N		Y	N
High Blood Pressure			Osteoarthritis			Hepatitis		
Heart Disease (Pacemaker/Defibrillator)			Rheumatoid Arthritis			Nerve Problems		
Blood Clot			Gout			Stomach Ulcer		
Diabetes Type I / II			Depression			Thyroid Disorder		
Stroke			Aneurysm			Sleep Apnea		
Seizure			Substance Abuse			Emphysema/COPD		
Asthma			Bronchitis			Liver/Kidney Disease		
Cancer			HIV/AIDS			Cholesterol		

Social History:	Y	N	If YES List Type:	Quantity	How Often?	How Long?	Date Last Used?
Tobacco							
□ Current everyday smoker □ Current some day smoker □ Former smoker □ Never smoked							
Alcohol							
Drugs							
Exercise							

Past Surgeries and/or Hospitalizations:	Year:	Past Surgeries and/or Hospitalizations:	Year:

How did you hear about our office/physician?

□ Previous Patient. When were you last seen? _____

□ Family Member was previous patient. What is family member's name? _____

□ Friend. Whom may we thank? _____

□ Internet. What description did you search? _____

□ Employer. □ School. If so, please list name _____

□ Telephone book. □ Paper. □ Online. If so, which one? _____

□ Physician referral. Please provide physicians name: _____

Patient/ Guardian Signature: _____ Date: _____