



Dean D. Worthingstun ~ Blue Ridge GA 30513

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:

- Anemia, Chronic
- Anxiety
- Asthma
- Irregular Heartbeat
- Bipolar Disorder
- Breast Cancer
- Hyperlipidemia
- Ischemic Heart Disease
- Chronic Pain
- Colon Cancer
- COPD
- Coronary Artery Disease
- DVT (Blood Clot)
- Depression

- Diabetes: *Insulin*
- Diabetes: *Non-Insulin*
- End Stage Renal Disease
- GERD
- Hepatitis
- HIV / AIDS
- Hypercholesterolemia
- Hyperparathyroidism
- Hypertension
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma

Name: _____

- Multiple Myeloma
- Obesity: *Morbid*
- Obesity
- Prostate Cancer
- Pulmonary Embolism
- Radiation Therapy
- Fibromyalgia
- Rheumatoid Arthritis
- Sleep Apnea
- Seizures
- Stroke
- NONE
- Other

Past Surgical History

Have you had any surgeries on the following organs?

- Appendix (Appendectomy)
- Breast: *Lumpectomy*
SPECIFY: *Right Left Both*
- Breast: *Mastectomy*
SPECIFY: *Right Left Both*
- Colon (Colectomy): *Diverticulitis*
- Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Gastric Bypass
- Heart: Mechanical / Biological Valve Replacement
- Heart: Coronary Artery Bypass Surgery
- Heart: Heart Transplant
- Kidney: Kidney Stone Removal Kidney: Kidney Transplant
- Liver: Hepatectomy Liver: Liver Transplant

- Ovaries (Oophorectomy): Ovarian Cancer
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy): TURP
- Rectum: APR
- Skin: Basal Cell Carcinoma
- Skin: Melanoma
- Skin: Skin Biopsy
- Skin: Squamous Cell Carcinoma
- Uterus: Hysterectomy
- Uterus: Cesarean Section
- Uterus Uterine Cancer / Cervical Cancer
- NONE Other _____



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Orthopedic History

Have you had any of the following?

- Ankle Fracture
- Ankylosing Spondylitis
- Adhesive Capsulitis
- Bursitis
- Carpal Tunnel Syndrome
- Chronic Low Back Pain
- DISH
- Epidural Injections
- Fracture
- Gout
- Handedness -
SPECIFY: *Right Left Both*
- Hip Fracture

- HNP -
SPECIFY: *Cervical Lumbar*
- Metastatic Bone Disease
- Osteoarthritis
- Osteopenia
- Osteoporosis
- Polio
- Primary Bone Sarcoma
- Psoriatic Arthritis
- Rheumatoid Arthritis
- Rickets
- RSD
- Sciatica

Name: _____

- Scoliosis
- Shoulder Impingement
- Spine Fracture
- Soft Tissue Sarcoma
- Spinal Stenosis:
SPECIFY: *Cervical Lumbar*
- Vertebral Body Compression Fracture
- Vitamin D Deficiency
- Wrist Fracture
- NONE
- Other

Orthopedic Surgical History

Have you had any of the following?

- Achilles Tendon Repair
- ACL Reconstruction
- Ankle Fracture ORIF
SPECIFY: *Right Left Both*
- Carpal Tunnel Decompression
SPECIFY: *Right Left Both*
- Cervical Spine Surgery: *ACDF*
- Cervical Spine Surgery: *Disc Replacement*
- CMC Arthroplasty
- Distal Radius ORIF
SPECIFY: *Right Left Both*
- Ganglion Cyst
- IMN *Femur*
SPECIFY: *Right Left Both*

- IMN *Tibia*
SPECIFY: *Right Left Both*
- Joint Replacement: *Hip*
SPECIFY: *Right Left Both*
- Joint Replacement: *Knee*
SPECIFY: *Right Left Both*
- Joint Replacement: *Shoulder*
SPECIFY: *Right Left Both*
- Knee Arthroscopy
SPECIFY: *Right Left Both*
- Kyphoplasty / Vertebroplasty
- Lumbar Fusion
- Lumbar Laminectomy
- Lumbar Spine: *Decompression*
- Lumbar Spine: *Decompression and Fusion*
- Lumbar Spine: *Disc Replacement*

- Meniscus Repair
- Reverse Total Shoulder Replacement
- Revision of Total *Hip* Arthroplasty
- Revision of Total *Knee* Arthroplasty
- Revision of Total *Shoulder* Arthroplasty
- Rotator Cuff Repair
SPECIFY: *Right Left Both*
- Shoulder Arthroscopy
- Trigger Finger Release
- NONE
- Other



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Orthopedic Family History

Name: _____

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

- Charcot Marie Tooth Disease
- Diabetes
- Hypertension
- Multiple Hereditary Exostosis
- Osteoarthritis
- Osteoporosis
- Scoliosis
- NONE
- Other _____

Orthopedic Pediatric History

Is there a personal history of any of the following?

- Cerebral Palsy
- Spina Bifida
- NONE
- Other _____

Social History

Smoking Status (please choose one):

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

Alcohol Intake (please choose one):

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

Exercise Frequency (please choose one):

- Several times a day
- Once a day
- Few times a week
- Few times a month
- Never

Pneumonia Vaccination: Yes / No

Flu Vaccination: Yes / No



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Medications:

Name: _____

Please list ALL current medications (or check the box if it applies)

Currently not taking any medication(s)

Medication	Dosage	Frequency

Allergies

Please list ALL known allergies (or check the box if it applies)

No Known Allergies (NKA)

Using the following options, describe your reaction(s) with severity provided below

Reaction Types	Severity Scale
Anaphylaxis Angioedema Diarrhea Dizziness Fatigue GI upset Hives Liver toxicity Nausea Rash Shortness of breath Swelling Weal Other: (specify)	Mild Mild to Moderate Moderate Moderate to Severe Severe Fatal

Allergy	Reaction(s)	Severity
1.) _____	_____	_____
2.) _____	_____	_____