Hand Therapy Associates
Patient Medical History

Patient Name_____ Date_____

MEDICATION	DOSAGE	FREQUENCY

Any medication allergies? ___Yes ___No _____

_____

Are you allergic to anything else? (i.e. latex, adhesive)_____

_____

Do you currently smoke? ___ Yes ___ No If yes, number of packs/day:_____

Have you had a fall in the past two years? ___Yes ___No When?_____

Past medical history (Heart condition, Hypertension, HIV, Hepatitis, Diabetes, any injuries)_____

_____

Hospitalizations/surgeries and dates of service:_____

_____

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