Greg M. Balourdas, M.D.

Surgery of the Hand

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Medical History / History of Injury

Today's Date:___/___/___ Date of injury or onset of problem___/___/___

Patient Name:______________________________ Home Phone: ( )______________

Address:______________________________ City:______________ Zip:______________

Age:________ Birthdate:___/___/___ Sex:______ Social Security No.:_____-____-______

Employer's Name______________________________ Work Phone:( )____________

Employer's Address______________________________ City:______________ Zip:__________

Work Comp.Ins.Carrier______________________________ Phone:( )____________

Adjuster:______________________ Claim #:______________ WCAB #:______________

Attorney:______________________ Address:______________ City:______________

Occupation at time of injury:____

Length of employment prior to injury__________Years__________Months

Describe accident / injury / exposure. (Please be as detailed as possible:How it happened; etc.)

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____

Primary complaint at time of injury.____

____

Current complaints:(Give details: area involved, weakness,loss of motion;pain: severity, frequency, activity)

____

____

Things I can't do:____

____

Things that aggravate my symptoms:____

____

DISABILITY INFORMATION

Did you continue working at the time of the injury? ( ) Yes ( ) No
Are you working now? ( ) Yes ( ) No, If not; last day you worked___/___/___
Employer:______________________________
Are you still working for same employer ( )Yes ( )No
List dates of disability from this injury: ___/___/___ to ___/___/___
Have you ever been disabled for any other reason? ( )Yes ( )No
When?___/___/___ to ___/___/___ Why?______________________
When?___/___/___ to ___/___/___ Why?______________________
Are you doing the same job as when you were hired? ( )Yes ( )No
If not what are you doing that's different? ______________________________

____

OTHER INJURIES

INDUSTRIAL

1.Employer______________________ Date___/___/___ Body part injured______________

2.Employer______________________ Date___/___/___ Body part injured______________

3.Employer______________________ Date___/___/___ Body part injured______________

NON-INDUSTRIAL

4.______________________ Date___/___/___ Body part injured______________

5.______________________ Date___/___/___ Body part injured______________

6.______________________ Date___/___/___ Body part injured______________

LIST ALL DOCTORS WHO YOU HAVE SEEN FOR YOUR CURRENT INJURY

Doctor______________________ Speciality______________ City__________

Doctor______________________ Speciality______________ City__________

Doctor______________________ Speciality______________ City__________

Have you ever had an injury like this before? ( )Yes ( )No

Are you or have you taken any medication for this injury? ( )Yes ( )No

Medication______________________ Medication______________________

Have you had any tests for this injury? Blood tests ( ), Xrays ( ), CT scan ( ), MRI scan ( ), Bone scan ( ), EMG/Nerve conduction studies ( ), Vascular studies ( ).
Other______________________________

WORK HISTORY
(latest employer first)

Employer______________________ Job______________________ Dates___/___to___/___

Employer______________________ Job______________________ Dates___/___to___/___

Employer______________________ Job______________________ Dates___/___to___/___

DESCRIBE JOB AT THE TIME OF INJURY

TITLE________________________________ Years at job__________

Please describe job tasks during a typical workday: Hours spent:

Sitting	1 2 3 4 5 6 7 8
Standing	1 2 3 4 5 6 7 8
Crawling	1 2 3 4 5 6 7 8
Climbing	1 2 3 4 5 6 7 8

Other Activities:

	Not at all	Less than 1/3rd of the work day.	1/3 to 2/3rds of the work day.	Greater than 2/3rds of the work day.
Pushing/Pulling	( )	( )	( )	( )
Typing	( )	( )	( )	( )
Reaching above shoulders	( )	( )	( )	( )
Reaching above head	( )	( )	( )	( )
Lifting/Gripping 0 to 10 lbs.	( )	( )	( )	( )
Lifting/Gripping 10 to 25#	( )	( )	( )	( )
Lifting/Gripping 25 to 50#	( )	( )	( )	( )
Lifting/Gripping 50 to 100#	( )	( )	( )	( )
Lifting/Gripping over 100#	( )	( )	( )	( )

Are your hands used for repetitive actions?, such as:

	Simple Grasping	Firm Grasping	Fine Manipulation	Writing
Right Hand	( )	( )	( )	( )
Left Hand	( )	( )	( )	( )

Please make any additional comments related to your current problem____________________

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To the best of my knowledge the above is accurate and complete.

Signed ______________________________Date ____/____/____