BROWARD HAND CENTER

**HARRIS GELLMAN M.D.**
**PURNELL TRAVERSO M.D.**

# MEDICAL QUESTIONNAIRE

PATIENT'S NAME _____ _____ _____ AGE _____ SEX: M F
(First) (MI) (Last) Circle

WHO REFERRED YOU TO DR. GELLMAN/DR. TRAVERSO?

**REFERRING PHYSICIAN**: _____

PHONE: (____) - _____ FAX: (____) - _____

ADDRESS: _____ _____ _____ _____
Street Suite City State Zip Code

**PRIMARY CARE PHYSICIAN**: ☐ SAME AS ABOVE ☐OTHER:

_____

PHONE: (____) - _____ FAX: (____) - _____

ADDRESS: _____ _____ _____ _____
Street Suite City State Zip Code

REASON FOR TODAY'S VISIT: _____

_____

HOW LONG HAVE YOU BEEN EXPERIENCING THESE SYMPTOMS? _____

ARE YOU?: ☐RIGHT-HANDED ☐LEFT-HANDED ☐AMBIDEXTROUS

WHAT DID YOU INJURE? ☐THUMB ☐HAND ☐ELBOW ☐OTHER: _____
☐FINGER ☐WRIST ☐SHOULDER

**WHAT SIDE?: ☐RIGHT ☐LEFT**

DATE OF INJURY _____ / _____ /_____ DATE YOU LAST WORKED: _____ / _____ /_____
MM DD YYYY MM DD YYYY

CURRENT WORK STATUS (CHECK ALL THAT APPLY): ☐NOT WORKING ☐LIGHT DUTY ☐FULL DUTY
☐**SEDENTARY** ☐**DISABLED**

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? ☐YES ☐NO

IF YES, WHAT FOR? _____

LIST ALL MEDICATIONS: _____

_____

ALLERGIES: _____



3100 Coral Hills Drive, Suite 305
Coral Springs, FL 33065
(O): 954-575-8056 (F): 954-575-2563

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PREVIOUS SURGERIES: ☐APPENDIX ☐BREAST ☐COSMETIC ☐EAR/NOSE/THROAT
☐GALL BLADDER ☐HEART ☐OB/GYN ☐PROSTATE
☐STOMACH/BOWEL ☐THYROID ☐TONSILS ☐VASCULAR

☐PRIOR ORTHOPEDIC SURGERY (WITH DATES): _____

☐OTHER: _____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

| YES / NO | YES / NO | YES / NO | YES / NO |
|---|---|---|---|
| ☐ ☐ AIDS/HIV | ☐ ☐ PSYCHIATRIC | ☐ ☐ DIABETES | ☐ ☐ CANCER |
| ☐ ☐ ANGINA | ☐ ☐ SEIZURES | ☐ ☐ HYPERTENSION | ☐ ☐ STROKE |
| ☐ ☐ ARRHYTHMIA | ☐ ☐ STOMACH ULCER | ☐ ☐ LOW BACK PAIN | ☐ ☐ URINARY TRACT INFECTION |
| ☐ ☐ ASTHMA | ☐ ☐ DEPRESSION | ☐ ☐ MIGRAINES | ☐ ☐ TUBERCULOSIS |
| ☐ ☐ BIRTH DEFECTS | ☐ ☐ EMPHYSEMA | ☐ ☐ PHLEBITIS | ☐ ☐ HEADACHES |
| ☐ ☐ BLOOD CLOTS/EMBOLISM | ☐ ☐ HEART MURMURS | ☐ ☐ BLOOD TRANSFUSION | ☐ ☐ HEART ATTACK |
| ☐ ☐ PNEUMONIA | ☐ ☐ HEPATITIS | ☐ ☐ BRONCHITIS | |

DO YOU SMOKE? ☐ YES ☐ NO IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW MUCH PER WEEK? _____

ARE YOU PREGNANT? ☐ YES ☐ NO ☐ NOT APPLICABLE

DO YOU HAVE A FAMILY HISTORY OF ANY MEDICAL CONDITIONS? (PLEASE LIST) _____

_____

PLEASE LIST ANY OTHER INFORMATION YOU THINK MAY BE HELPFUL/IMPORTANT? _____

_____

**EMERGENCY CONTACT:** _____ **RELATIONSHIP:** _____

PHONE: (_____) - _____

*THE INFORMATION I HAVE GIVEN ABOVE IS COMPLETE AND ACCURATE. AS WITH ALL MEDICAL RECORDS, THE INFORMATION YOU HAVE PROVIDED WILL BE CONFIDENTIAL.*

_____ DATE COMPLETED _____ / _____ /_____
PATIENT'S SIGNATURE MM DD YYYY



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