Patient Name: _____ **DOB:** _____ **Age:** _____ **PAGE 1**

The New York Hand and Wrist Center of Lenox Hill
Phone *212-434-4263*
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Co-Directors
Steven Beldner, MD
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CONFIDENTIAL MEDICAL HISTORY

Hand Dominance: ☐Left ☐Right ☐Ambidextrous **Current Height**: ____ ft. ____ in. **Current Weight**: ____ lbs.

Primary Care Physician: _____ Contact Phone#/Fax#: _____

Address: _____

Referring Physician: _____ Contact Phone#/Fax#:_____

Address: _____

Would you like a letter/visit summary be sent to your Primary Care Physician? ○ *Yes* ○ *No*

What is the reason for your visit today? _____

How did the injury occur? _____

Is this work related? ○Y ○N Is this related to a car accident? ○Y ○N Date of Injury? _____

How long have you had symptoms? _____ Who have you seen for this condition? _____

Have you had similar problems in the past? ○Y ○N If yes, explain: _____

STUDIES AND TREATMENTS:

Please check any treatment(s) you have had:

- ☐ Activity Modification
- ☐ Splints, Braces, Wraps
- ☐ Medications (ie NSAIDS, Advil, Aleve, Motrin etc.)
- ☐ Therapy
- ☐ Other: _____

Please check any studies you have had and include dates

- ☐ X-ray _____
- ☐ MRI/CT Scan _____
- ☐ EMG _____
- ☐ Other: _____
- ☐ _____

LOCATION OF PROBLEM:

Elbow	Wrist	Hand	Thumb	Index	Middle	Ring	Small
☐L ☐R	☐L ☐R	☐L ☐R	☐L ☐R	☐L ☐R	☐L ☐R	☐L ☐R	☐L ☐R

MEDICAL CONDITIONS: To the best of your knowledge, have you ever had a serious medical problem related to the following?

Skin Rashes or disorders	○Y ○N	Osteoporosis	○Y ○N	Ears, eyes, nose or throat	○Y ○N
Bladder or kidneys	○Y ○N	Breasts	○Y ○N	Stomach, intestines	○Y ○N
Lung disease	○Y ○N	Epilepsy or stroke	○Y ○N	Heart disease	○Y ○N
Thyroid	○Y ○N	High blood pressure	○Y ○N	Diabetes	○Y ○N
HIV, Hepatitis	○Y ○N	Cancer	○Y ○N	Liver, gallbladder	○Y ○N
Blood disorders	○Y ○N	Kidney Disease	○Y ○N	Prostate/Bladder	○Y ○N
Sleep Apnea	○Y ○N				

PAST SURGERIES:

☐**No Past Surgery/Hospitalizations**

Operation	Surgeon	Year	Complication, if any

FAMILY HISTORY: Have any family members had the following?

☐**No Pertinent Family History**

		Whom	Type	Location
Arthritis/DJD	○Y ○N			
Cancer	○Y ○N			
Genetic Disease	○Y ○N			
Osteoporosis	○Y ○N			

Patient Name: _____ DOB: _____ Age: _____

SOCIAL & PERSONAL HISTORY:

Do you smoke tobacco products? ☐Y ☐N If Yes, ___ pack(s) per day for _____ years

Are you an ex- smoker? ☐Y ☐N If Yes, ___ pack(s) per day for _____ years

How often do you drink alcohol? ☐Daily ☐Frequently ☐Occasionally ☐ Never

Any history of substance abuse? ☐Y ☐N If Yes, please explain _____

Please list any recreational activities you enjoy : _____

ALLERGIES:

☐**No Known Allergies**

☐ Shellfish	☐ Contrast Dye	☐ Latex	☐Medications: _____
☐ Seasonal	☐ Latex	☐ General/Local	☐ Other: _____

CURRENT MEDICATIONS: Please list all medications.

☐**No Current Medications**

Are you on any blood thinners? ☐Y ☐N ***If Yes, (please circle): Coumadin, Plavix, Aspirin, Pradaxa***

Name	Dose/Frequency	Reason

REVIEW OF SYMPTOMS: *Please check any of the following symptoms you have experienced recently or are experiencing now*

☐Arthralgia	☐Nosebleeds	☐Vomiting	☐Change in Mole
☐Joint Pain	☐Sore Throat	☐Blood in Stool	☐Headache
☐Joint Stiffness	☐Chest Pain	☐Reflux	☐Dizziness
☐Joint Swelling	☐Palpitations	☐Pelvic Pain	☐Fainting
☐Fever	☐Fast Heart Rate	☐Painful Urination	☐Convulsions
☐Chills	☐Leg Swelling	☐Urethral Discharge	☐Anxiety
☐Fatigue	☐Shortness of Breath	☐Abnormal Vaginal Bleeding	☐Feeling Weak
☐Recent Weight Gain	☐Cough	☐Urinary Frequency	☐Muscle Weakness
☐Eye Discharge	☐Shortness of Breath w/Exertion	☐Urinary Urgency	☐Hot Flashes
☐Eye Pain	☐Wheezing	☐Incontinence	☐Deepening of the Voice
☐Vision Problems	☐Abdominal Pain	☐Erectile Dysfunction	☐Easy Bleeding
☐Red Eye	☐Constipation	☐Breast Pain	☐Easy Bruising
☐Decrease Hearing	☐Diarrhea	☐Breast Lump	☐Swollen Glands
☐Nasal Discharge	☐Heartburn	☐Skin Lesions	☐Neck Lymph Nodes Enlarged

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To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information or omitting information may be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status with each and every visit. I also authorize the health care staff to perform the necessary services I may need.

_____

Signature of Patient **Date**

For Office Use Only:

_____

Physician Signature **Date**

Informed Consent for Telehealth Services During a Public Health Emergency

By virtue of my participation in this telehealth visit, I am consenting to receive care through telehealth. Telehealth is the use of electronic information and communication technologies by providers to deliver health care to patients at a distance.

I understand that any care provided to me through Northwell Health Inc.'s telehealth application ("the Northwell app") will incorporate security protocols to protect the privacy and security of my health information. If any other application is used to provide care to me, I understand that the technology may not contain appropriate security protocols to protect the privacy and security of my health information. My provider has explained to me the risks associated with the technology platforms that he or she is using to provide care to me. I acknowledge that there are potential risks associated with any technology used while obtaining care through telehealth, including, but not limited to, connectively interruptions, other technical difficulties, and unauthorized access by a third party to one's health information. Despite these risks, I agree to participate in the telehealth encounter.

I understand and agree that I or my healthcare provider may terminate a telehealth encounter at any time in the event of a technical malfunction.

I also understand that my location determines where medicine is being practiced. As a result, I will inform my provider where I am located at the time of my telehealth visit.

I understand that there may be costs associated with a telehealth visit. I agree that I am responsible for any fees associated with the telehealth services that I receive.

This Informed Consent for Telehealth Services During a Public Health Emergency will remain in effect solely during the term of the public health emergency.

By signing below I certify that:

I have read or had this form read and/or had this form explained to me;

I fully understand the contents of this document, including the risks and benefits of receiving telehealth services; and

I have been given ample opportunity to discuss any questions I may have regarding the telehealth services and that all of my questions have been answered to my satisfaction.

Patient/Agent/Surrogate/Guardian* (Signature):	Date:
Printed name of person signing this form:	Authority to sign on behalf of patient or relationship to patient (if applicable):

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or lacks capacity to make medical decisions. In these cases the Agent, Surrogate or Guardian should sign.

Only for use when interpreter services are utilized for the completion of this form:

_____

Telephonic Interpreter's ID # Date/Time

OR

_____ _____

Signature: Interpreter Date/Time Print: Interpreter's Name and Relationship to Patient

_____ _____

Witness to Signature Print Witness Name