DAVID LINCOLN NELSON, MD

SURGERY OF THE HAND AND WRIST MICROSURGERY

Diplomate, American Board of Orthopedic Surgery
Certificate of Added Qualifications in Surgery of the Hand

1363 South Eliseo Drive, Suite B Greenbrae, CA 94904
Telephone: 415-925-0501 Fax: 415-461-4274

Welcome to my office. I appreciate your coming to see me and hope that I can help you with your hand problem. In order to make sure that I get the history of your problem correct, I ask that you fill out three pages of information. I have designed them myself to be as quick and painless as possible. Print out this each page and bring them in with you. Do not email them to me. If your hand problem makes it difficult for you to fill this out, please ask my secretary to help you. My staff and I are here to serve you. Please let me know how we can serve you better.

Name _____ Age_____ Date _____

Referred by _____Work related? Yes ☐ No ☐

Is the problem on the right, left, or both? (Circle one) Are you right or left handed? Right ☐ Left ☐

Are you working now? Yes ☐ No ☐

What do you normally do for a living?_____
_____

When did problem start? Date: _____

What is the MAIN PROBLEM that you want me to examine? I just need a very simple description at this time, for example, "pain in my right thumb," or "numbness in my left hand."
_____

What are the OTHER PROBLEMS that you would like examined today? Just a simple list will do for now.
_____

Describe how the main problem first started.
_____
_____
_____

PRINT these pages and complete them. I look forward to meeting you and helping you with your problem.

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Name_____
Address _____City _____ ZIP_____

Birthdate _____/_____/_____ Phone (home)_____ (work) _____

Employed by_____How long? _____
Address _____ SS# _____

Marital status (circle one): married single widowed divorced partner

Name of spouse_____

Employed by_____

Work address_____Phone _____

Name of insurance company_____

Policy / Medicare # (skip this if you can bring in your card)_____

Group # (skip this if you can bring in your card) _____

Name of person responsible for payment_____

Name of referring physician_____

Family physician_____

Other physicians_____

I, the undersigned have insurance with_____and assign directly to David Lincoln Nelson, MD, all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. PAYMENT IS REQUESTED AT THE TIME OF VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE MANAGER.

Signed _____ Date _____

Thank you for filling out this form. I look forward to meeting you and helping you with your problem.

David Lincoln Nelson, MD

Medical History

NAME:_____DATE OF BIRTH_____

Present medications: (name and dose)
Allergies: (medication name)
Previous operations: (when and where)
Previous hospitalizations: (when and where)
Have you ever smoked? yes ☐ no ☐ Most you ever smoked? ___packs/day How many years? _____If you quit, when _____
Do you drink alcohol? none ☐ occasionlly ☐ daily ☐
Do you use recreational drugs? yes ☐ no ☐ Have you ever used intravenous drugs? yes ☐ no ☐

PLEASE INDICATE YES OR NO TO THE FOLLOWING QUESTIONS: Have you ever had:

	Yes	No		Yes	No		Yes	No
heart problems			thyroid problems			stroke		
high blood pressure			kidney problems			venereal disease		
irregular pulse			hepatitis/jaundice			high risk acts for AIDS		
chest pain/angina			hiatial hernia/heartburn			steroid treatments		
respiratory problems			problems with taking motrin or NSAIDs			alcohol addiction		
asthma			ulcers			drug addiction		
seizures/epilepsy			bleeding problems			special diet		
numbness/weakness			transfusions			difficulty urinating		
diabetes			anemia			history of childhood abuse		
could you possibly be pregnant?			arthritis			HIV infection		
neck pain			back pain			alternative health care		

EXPLANATION OF ABOVE/OTHER MEDICAL PROBLEMS:_____
_____

FAMILY HISTORY

RELATIVE	LIVING	WELL	DEAD	AGE now or at time of death	CAUSE of illness
Father					
Mother					
Spouse					
Children					

HAS ANY BLOOD RELATIVE?

	YES	NO	IF YES, INDICATE WHO
had early heart disease			
been an alcoholic/drug addict			
had gout			
had unusual bleeding tendencies			
had death during anethesia			

SIGNATURE_____DATE_____