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The Hand & Upper Extremity
CENTER OF GEORGIA, P. C.
SURGERY OF THE HAND, ELBOW AND SHOULDER

Northside Hospital Doctors Centre
980 Johnson Ferry Road NE, Suite 1020
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Hand & Upper Extremity Surgery Center
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(404) 255-0226 • www.HandCenterGA.com

Medical History

PATIENT'S INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Age: _____

Dominant Hand: Right Left Social Security #: _____

REASON FOR TODAY'S VISIT

Description: _____

Is your visit today the result of an accident? Yes No

If Yes, what type of accident? Automobile Work Related

Other: _____

Have you seen another physician or been treated previously for this condition/injury?

Yes No

If yes, whom did you see? _____

Have you been treated by a physician for any reason in the last 6 months? Yes No

If yes, who did you see and for what were you treated? _____

Are you allergic to any drugs? Yes No

If yes, please list: _____

Have you had any prior surgeries? Yes No

If yes, please indicate type of surgery and approximate date: _____

Patient Name: _____

Date: _____

Please indicate if you suffer from any of the following conditions and what medications you take in treatment of those conditions:

Condition	Yes	No	Describe	Medications I Take
AUTOIMMUNE/ARTHRITIS:				
Rheumatoid Arthritis				
Systemic Lupus Arthritis				
Sarcoid Arthritis				
Juvenile Arthritis				
Gout				
AIDS				
Other Autoimmune Issues				
HEART/CIRCULATION:				
High Blood Pressure				
High Cholesterol				
Abnormal Rhythms				
Clotting Problems				
Other Circulation Issues				
LUNG/PULMONARY:				
COPD				
Emphysema				
Asthma				
Tuberculosis				
Other Pulmonary Issues				
OTHER:				
Kidney or Renal Issues				
Diabetes				
Thyroid				
Other Conditions				
Do you smoke?				
Substance Abuse?				
Are you HIV positive?				
Are you pregnant?				
Do you have a history of drug resistant infection, i.e. MRSA?				

Are you currently taking any other medications that you have not listed above? [] Yes [] No
If yes, please list: _____

Are you currently taking any supplements, multi-vitamins or herbal supplements? [] Yes [] No
If yes, please list: _____

Have you recently taken the antibiotic drugs CIPROFLOXACIN or LEVAQUIN? [] Yes [] No

Signature of Patient _____

Date _____