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Joshua A. Ratner, M.D.
Bryce T. Gillespie, MD.

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
Atlanta, Georgia 30342

Northside/Alpharetta Medical Campus
3400A Old Milton Parkway, Suite 350
Alpharetta, Georgia 30005

Hand & Upper Extremity Surgery Center
993D Johnson Ferry Road NE, Suite 200
Atlanta, Georgia 30342

(404) 255-0226 • www.HandCenterGA.com

PATIENT'S INFORMATION

Name:____

Date of Birth: _______________________________

Today's Date: _______________________________

Primary Care Physician: ___________________________ Referral Source: ______________________________

Age: ________ Spoken Language: __________________ Race: __________ Ethnicity: _________________

Marital Status: Single:_____ Married:_____ Widow:______ Divorced:_______ Partner:______

Right Handed:_________ Left Handed:_________ Male:_______ Female:______

Reason For Today's Visit: ____

Is This Due To An Injury? Yes _____ No _____ If Yes, Date Of Injury___________________________

Workers Compensation Claim? Yes _____ No _____ Motor Vehicle Accident? Yes _____ No _____

Litigation Pending? Yes ____ No ____

Circle All Current As Well As Previous Illnesses:

Height: _____________ Weight: ________________

Asthma/Bronchitis / Emphysema Yes / No
Osteoarthritis/Rheumatoid Yes / No
Stroke/ TIA Yes / No
Epilepsy/ Seizure Yes / No
Thyroid/ Goiter Yes / No
Other____________________________________
Mental Illness Yes / No
Sleep Apnea Yes / No
Diabetic Type _____ Yes / No
History Of Cancer Yes / No
Type ____

Blood Pressure: ________________
High Blood Pressure Yes / No
Atrial Fib Yes / No
Pacemaker Yes / No
Cardiac Stents Yes / No
History Of MRSA Yes / No
If Complications With Anesthesia Please Explain________________________________
Recent Usage Of Cipro/ Levaquin Yes / No
Up to date with Immunizations? Yes / No

Do You Have Any Other Medical Conditions That Affect Your Bones Or Joints? __________

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Social History

I Use Alcohol: Never______ Rarely ______ Moderate ______ Daily ______

I Smoke: Never ______ Current Packs/Date______ Quit In ______

Hobbies And Sport(s) Activities I Enjoy: ____

Type Of Work: ____

Please List Any Drug Allergies: ____

Please List Any Other Allergies: ____

Please List All Current Medications

Name	Dosage	Name	Dosage

If you have more medications that need to be listed, please list on the other side of this paper

Please List All Surgeries

______________________________ Date: ________ ______________________________ Date: ________

______________________________ Date: ________ ______________________________ Date: ________

______________________________ Date: ________ ______________________________ Date: ________

______________________________ Date: ________ ______________________________ Date: ________

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Name:____

Date of Birth: ______________________________

Today's Date: ______________________________

Family History	Major Illnesses	Please Indicated If Deceased

Mother: ____

Father: ____

Siblings: ____

Family History Of Malignant Hyperthermia? Yes / No

Systems Review- Please Circle Your Answer(s)

Constitutional Symptoms	
Good General Health	Yes / No
Recent Weight Change	Yes / No
Fever	Yes / No
Fatigue	Yes / No
Eyes	
Wear Glasses	Yes / No
Wear Contacts	Yes / No
Glaucoma	Yes / No
ENT	
Hearing Loss/ Ringing	Yes / No
Earaches Drainage	Yes / No
Chronic Sinus Problems	Yes / No
Nose Bleeds	Yes / No
Bleeding Gums	Yes / No
Sore Throat/ Voice Change	Yes / No
Cardiovascular	
Chest Pain	Yes / No
Palpitations	Yes / No
Swelling Feet Hands	Yes / No
Angina	Yes / No

Genitourinary	
Frequent Urination	Yes / No
Painful Urination	Yes / No
Blood In Urine	Yes / No
Kidney Stone	Yes / No
Gastrointestinal	
Loss Of Appetite	Yes / No
Nausea	Yes / No
Vomiting	Yes / No
Abdominal Pain	Yes / No
Ulcer	Yes / No
Hepatitis A/ B/ C	Yes / No
Neurological	
Lightheadedness	Yes / No
Tremors	Yes / No
Paralysis	Yes / No
Psychiatric	
Depression	Yes / No
Memory Loss	Yes / No
Insomnia	Yes / No
Nervousness	Yes / No

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Pulmonary
- Chronic Frequent Cough Yes / No
- Shortness Of Breath Yes / No
- Exposure To HIV Yes / No

Musculoskeletal
- Osteoporosis Yes / No
- Scoliosis Yes / No

Skin
- Rash Yes / No

Hematologic/Lymphatic
- Anemia Yes No
- Blood Transfusion Yes / No

Endocrine
- Hot/ Cold Intolerance Yes / No
- Rheumatoid Disease Yes / No
- Are You Currently Pregnant? Yes / No

Information Verified With Patient Today With The Following Changes Noted:

____

____

____

Patient Signature:____ Date:_________

Reviewed By:____ Date:_________