Hand Questionnaire

Today's Date_____

First Name _____ Last Name _____

Date of Birth _____ Occupation _____

Gender: o Male o Female Height _____ Weight _____

HISTORY

Handedness: o Right o Left

Which hand is causing concern? o Right o Left If both, which is worse? o Right o Left

What is the main problem that brought you to see the doctor today? _____

_____

How long have you had symptoms or when were you first injured? Please list the exact date, if possible.

_____

Is this a work-related injury? o Yes o No Employer: _____

Please rank the severity of your symptoms: o Mild o Moderate o Severe

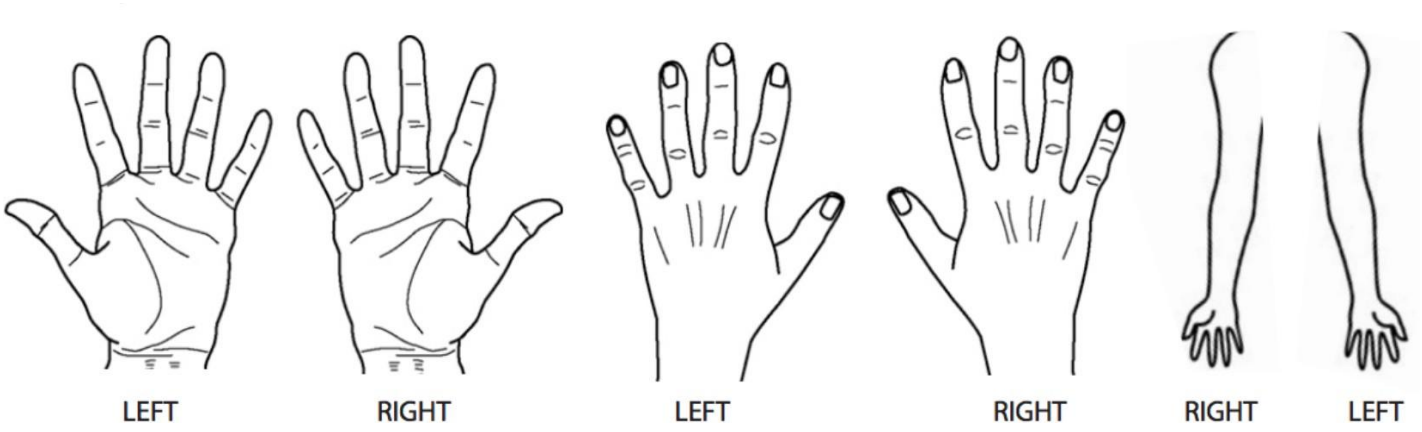
Timing: o On and off o Constant o Morning o Nighttime

Describe your quality of pain: o Dull o Throbbing o Sharp o Burning o Numbness o Tingling o Ache

o Other: _____

Please list any hobbies, sports or special uses of your hands: _____

Please use diagram to show problem areas:



TREATMENT & MEDICATIONS

What makes your symptoms better? _____

What makes your symptoms worse? _____

Please list any prior treatment you have had for this problem, and whether it has helped.

Medications (type): _____

Splints (type, wear day/night/both): _____

Injections (dates, exact location): _____

Surgery (dates/description): _____

Other: _____

How did you find out about us? _____