Hand Center of Nevada

Comprehensive Care for the SHOULDER, ELBOW, WRIST & HAND

FAMILY PHYSICIAN **We must have the FAX # so that we can fax a copy of your office visit report.*

Physician Name:_____ Practice Name:_____

Address:_____

Phone #:_____ *Fax:_____

HISTORY

Name:_____ Age:_____

Briefly, what problem are you being seen for today?_____

When did the problem start/Date of injury?_____

Affected Side(circle one): Right Left Both Which hand do you write with? (circle one): Right Left Both

Referred by (Doctor, Family/Friend, Online, Advertisement):_____

Occupation:_____ Employer:_____

Describe how your problem started (use the back if you need more room):_____

_____

If you were injured, where did the injury occur(circle one)? Work Home School Sports Car Accident

Other(please describe):_____

CURRENT MEDICATIONS / ALLERGIES TO MEDICATIONS

Name of Medication(may attach list)	Dosage	Name of Medication	Reaction

PAST MEDICAL HISTORY (Please circle or write)

Anxiety	Carpal Tunnel	GERD/Stomach Ulcers	High Cholesterol	Prostate Problems	Stroke
Asthma	Cubital Tunnel	Gout	Kidney Disease	Seizure Disorder	Substance Abuse
Anemia	Depression	Heart Disease	Neck/Back Problems	Scleroderma	Thyroid Disease
Cancer	Diabetes	High Blood Pressure	Pacemaker	Sleep Apnea	

Other:_____

PAST SURGICAL HISTORY (Please circle or write)

Angioplasty	Carotid Surgery	Cubital Tunnel Release	Hernia Repair	Laparoscopy	Spine Surgery
Appendectomy	Carpal Tunnel Release	Foot Surgery	Hysterectomy	Oral Surgery	Tonsillectomy
C-section	Cosmetic	Fracture Care	Joint Replacement	Prostate Surgery	Trigger Finger

Have you had any surgeries on your arms, legs or back? Yes No If yes, which ones?_____

_____

_____

Have you ever had any problems with anesthesia? Yes No If yes, please describe:_____

OCCUPATIONAL/SOCIAL HISTORY

What is your work status (circle one)? Full Duty Light Duty Not Working (Why?): _____

How long have you been at your current job?:_____

Do you have a lawsuit or are planning to file a lawsuit regarding your injury?_____

What is your attorney's name?_____

What are your hobbies? (i.e. golf/sports, knitting, TV, etc)_____

Do you live with others?:Yes No If yes, how many people live with you, and who are they?_____

Do you drink alcohol?: Yes No If yes, how many drinks per week?_____

SMOKING STATUS

Do you smoke? Yes No If yes, how many cigarettes a day?_____

What year did you start smoking?_____

Are you a former smoker? Yes No If yes, what year did you quit?_____

FAMILY HISTORY OF ILLNESS (Grandparents, Mother/Father, Siblings)

Does anyone in your family have any of the following illnesses? (circle all that apply)

Asthma Arthritis Cancer Diabetes Mellitus Dupuytren's Disease Gout

Heart Disease Kidney Disease Rheumatoid Arthritis

Other:_____

REVIEW OF SYSTEMS

Are you currently, or have you ever had, problems with:

	YES	NO
Constitutional		
Fever	☐	☐
Unexpected weight loss	☐	☐
Excessive fatigue	☐	☐
Loss of appetite	☐	☐
Eyes		
Wearing glasses or contacts	☐	☐
Glaucoma	☐	☐
Ears, Notes, Throat		
Wearing hearing aids	☐	☐
Ear infections	☐	☐
Sinus problems	☐	☐
Cardiovascular		
Chest pain or angina	☐	☐
Irregular pulse	☐	☐
Heart murmur	☐	☐
Heart attack	☐	☐
Blood clots	☐	☐
Do you have a Pacemaker?	☐	☐
Do you have a Defibrillator?	☐	☐
Respiratory		
Asthma	☐	☐
Emphysema/COPD	☐	☐
Chronic cough	☐	☐
Pneumonia	☐	☐
Lung cancer	☐	☐
Gastrointestinal		
Ulcers or gastritis	☐	☐
Colon Cancer	☐	☐
Hepatitis	☐	☐
Genitourinary		
Urinary tract infections	☐	☐
Kidney stones	☐	☐
Integumentary		
Skin cancer	☐	☐
Skin ulcers	☐	☐

	YES	NO
Musculoskeletal		
Broken Bones	☐	☐
Arm weakness/pain	☐	☐
Leg weakness/pain	☐	☐
Joint pain or arthritis	☐	☐
Osteoporosis	☐	☐
Back pain	☐	☐
Scoliosis	☐	☐
Neurological		
Balance problems	☐	☐
Headache	☐	☐
Fainting spells	☐	☐
Seizures	☐	☐
Stroke	☐	☐
Endocrine		
Diabetes	☐	☐
Thyroid Disease	☐	☐
Hormone problems	☐	☐
Hematologic/Lymphatic		
Anemia	☐	☐
Bleeding tendencies	☐	☐
Hemophilia	☐	☐
Blood transfusion	☐	☐
Lymphoma/Leukemia	☐	☐
Allergic/Immunologic		
Nasal allergies	☐	☐
Immunlogic disorders	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Other psychiatric disorders	☐	☐

The information provided on this form is accurate to the best of my knowledge.

_____

Signature Date

It is the patient's responsibility to notify us of any changes to the information provided.

QUICK DASH QUESTIONAIRE

1. Name: _____ 2. Age:_____

Please rate your ability to do the following activities in the last week by marking the appropriate box. If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
1. Open a tight or new jar	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Do heavy household chores	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Carry a shopping bag or briefcase	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Wash your back	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Use a knife to cut food	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Recreational activities in which you take some force or impact through your arm, shoulder, or hand (golf, hammering, tennis, etc)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	Not Limited	Slightly Limited	Moderately Limited	Very Limited	Unable
7. During the past week, to what extent has your arm, shoulder, or hand problem limited your normal social activities with family, friends, neighbors, or groups?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. During the past week, how much were you limited in your work or other regular daily activities as a result of your arm, shoulder, or hand problems?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	None	Mild	Moderate	Severe	Extreme
9. Rate the severity of your arm, shoulder, or hand pain in the last week	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. Rate the severity of tingling (pins and needles) in your arm, shoulder, or hand in the last week	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5