NAME: MR #: VISIT DATE:

PLEASE ANSWER QUESTIONS IN THIS COLUMN

Phone (Home) #________________(Cell)#______________

Age : ______ Occupation: ______________________________

Handedness? Right __ Left __ Ambidextrous __

Are You ? Married_ Single _ Divorced_ Widowed _

CURRENT HAND, WRIST, and /or UPPER EXTREMITY COMPLAINT(S) ?

Are You in PAIN ? Yes __ No __

PAIN INTENSITY ? Circle 1 2 3 4 5 6 7 8 9 10

Additional Hand/Arm Complaints? ______________________

____

When Problem Started? ____________

How Problem Started? __________________________

Work Comp Case? Yes__No__: No Fault? Yes__No__

Are You currently: Better? ___ Worse?___Same?____

Treatment to Date?_______________________________

PAST HISTORY: Operations___________________________

Medical Illness:___________________________________

Drug Alleries:______________________Latex Allergy Yes__No__

Medications:______________________________________

Aspirin Yes__ No__ ; Blood Thinner Yes__ No__

FAMILY HISTORY:Diabetes Yes__No__ ; Heart Yes__No__

Bleding Disorder Yes__No__ ; Anesthesia reaction Yes__No__

Cancer Yes__No__ ; Dupuytren's Disease Yes__No__

Who in family if Yes?______________________________

SOCIAL HISTORY: Smoke Yes__ No__ If Yes Pack/Day______

Drink alcohol? Yes__No__ Amount per week?___________

Hobbies, sports etc. ______________________________

Review of Systems: Do you have or take medicine for ?

Stomach Problem Yes__ No__ ; Arthritis Yes__ No__

Thyroid Disease Yes__ No__ ; Heart Disease Yes__ No__

Weight Loss Yes__ No__; Bladder/Prostate Problem Yes__No__

Neck Injury Yes__ No__ ; Neck Arthritis/Disk Yes__ No__

Diabetes Yes__ No__; Gout Yes__ No__; Cancer Yes__ No__

Seizures Yes__ No__ ; Bowel Disease Yes__ No__

Hypertension Yes__ No__ ; High Cholesterol Yes__ No__

Review of Systems: Do you have complaints related to ?

Head Yes__ No__ ; Eyes Yes__ No__; Ears Yes__ No__

Nose Yes__ No__ ; Throat Yes__ No__; Heart Yes__ No__

Lungs Yes__ No__ ; Abdomen Yes__ No__; Kidney Yes__ No__

Appetite Yes__ No__ ; Other Joints Yes__ No__

Other Medical Problem:_____________________________

Additional History Review Points: (+,- or blank)

Locking Digits __ ; Trauma __; Numbness__ ; Night Sx's___

Neck __ ; XS Drop __; Driving Sx's __; Fine Motor __; DM__

Thyroid__ ; Weaknes __; Dups Fx __; Seizures __; Peyronie's __

Foot Lumps __ ; Stiffness__ ; Wrist Click __ ; Mass __ ;

Enlarging __; Fluctuating Size __ ; Night Pain__ ; Wt. Loss__

Other____

EXAMINATION NOTES

Sensation: R L

Tinel Med R__ L__Tinel Ulnar (E) R__ L__Tinel Uln(G) R__ L__

Comp Test R__ L__Phalen Test R__ L__Ulnar Flex Test R__ L__

Thenar Atrophy R__ L__ ; 1st D Atrophy R__ L__

Thenar Strength R__ L__ ; 1st D Strength R__ L__

Finckelstein R__ L__ ; Thumb CMC R__ L__

Trigger I R__ L__ ; Trigger II R__ L__; Trigger III R__L__

Trigger IV R__ L__ ; Trigger V R__ L__

Scaphoid R__ L__ ; S-L R__ L__; Watson R__L__

Lunate R__ L__ ; T-L R__ L__; Shuck R__L__

TFCC R__ L__ ; McMurray R__ L__; ECU R__L__ P-T R__L__

Hook Hamate R__ L__ ; FCR R__ L__; FCU R__L__

ROM: R L

Other:

Xray(Imaging)___________________________________

____

Ultrasound______________________________________

Diagnoses_______________________________________

____

____

Plan____

____

____

Return to Work or Gym Date_________________________

Xiaflex: Get Drug: Single Dose ___ Double Dose ____

Circle **Right**: I, II, III, IV, V ; **Left**: I, II, III, IV, V & MP PIP DIP

ASC Yes__No__ ; **Clearance** Yes__No__; **Anticoag** Yes__No__

Schedule Surgery: Procedure__________________________

____

ASC Yes__No__ ; **R___L___; Anticoag** Yes__No__

Clearance Yes__No__; **Clearance** by Who?______________

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