HAND QUESTIONNAIRE

Patient Name: _____ DOB: _____

1.) Which hand(s) did you hurt? Describe your distribution of pain (i.e., top/palm of hand, thumb, index/long/ring/small fingers, forearm). Be specific.

_____

_____

2.) Do you have numbness or triggering/catching? Describe your distribution of numbness or triggering/catching (i.e. thumb, index/long/ring/small finger). Be specific.

_____

_____

3.) Is this work comp? Yes No Litigation pending? Yes No
What is your job description?

_____

___ hrs/day, ___ days/week What is your current job status? _____

4.) Where were you, and what were you doing, when you injured your hand?

_____

5.) When did you hurt your hand? _____

6.) When is the pain the worst? Be specific.

_____

7.) Rate your pain (0 for no pain, 10 for most pain): ___\10

8.) Describe your pain (circle all that apply):

sharp dull stabbing burning throbbing aching

9.) Do you have history of prior hand surgery? Yes no

10.) Do you have any of the following symptoms (circle all that apply)?

Locking catching popping clicking triggering
swelling numbness tingling weakness

11.) Do you have pain at night or at rest?

12.) Since the problem started, is the pain:

Getting better getting worse unchanged

13.) What makes the pain worse (circle all that apply)?

Driving typing sleeping exercise twisting lifting
repetitive use grasping throwing pushing pulling

Other: _____

14.) What improves your pain (circle all that apply)?

Rest ice heat non-use elevation Ibuprofen/Aleve Tylenol

Other: _____

15.) Do you smoke? Yes No If yes, ___ packs/day x ___ years

16.) Do you drink regularly? Yes No If yes, ___ drinks/day x ___ years

17.) Do you have prior history of hand pain? Yes no

If yes, did your prior treatment rendered by a physician include the following:

NSAIDs sling PT/OT Home exercises Injection

Narcotic meds Brace/splint/cast

Other:_____

18.) Did the treatment help? Yes No

19.) Have you had any x-rays/MRI/CT or other prior imaging studies? Yes No

If yes, what study and where was it performed? _____

I certify that I have read and understand the above information to the best of my knowledge, and that the above questions have been acurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to third party payors and/or health practicioners. I authorize and request my insurance company to pay directly to the physician insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature	MD/PA Signature	Date

Recall Review Signatures: Date:

1			
2			
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