THE CENTER
ORTHOPEDIC & NEUROSURGICAL CARE & RESEARCH

HAND, WRIST & ELBOW

For Office Use Only: Provider #_____

MRN #_____ Staff Initials _____

Appointment Date: _____/_____/_____ Name: _____

Date of Birth: _____/_____/_____ Age: _____ Dominant Hand: ❑ Right ❑ Left Primary Care Provider: _____

Who referred you today? ❑ Self ❑ Friend ❑ Provider _____

PLEASE CHECK YES OR NO IF YOU ARE FREQUENTLY BOTHERED BY, OR HAVE RECEIVED TREATMENT FOR:

Blood Clots	Yes ❑ No ❑	Diabetes	Yes ❑ No ❑	Lymphedema	Yes ❑ No ❑
History of Infection	Yes ❑ No ❑	Breast Cancer	Yes ❑ No ❑	Difficulty with Anesthesia	Yes ❑ No ❑
		Blood Thinner	Yes ❑ No ❑	Surgical Complications	Yes ❑ No ❑

What problem would you like us to address today? _____

_____

When did the problem start? _____

Is this problem because of an injury? ❑ Yes ❑ No

If yes, ❑ Motor Vehicle Accident ❑ Work ❑ Sports ❑ Other _____

Describe Injury _____

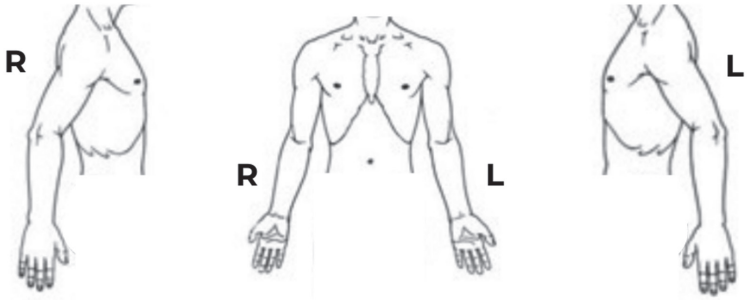
_____

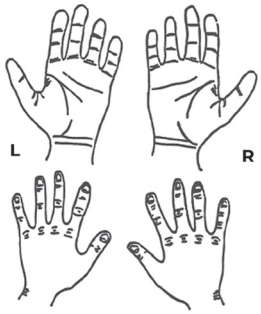
Date of Injury _____ Is there a work claim? ❑ Yes ❑ No

Job _____ Employer _____

Please describe your symptoms:
❑ Sharp Pain ❑ Numbness ❑ Clicking/Popping
❑ Burning Pain ❑ Tingling ❑ Weakness
❑ Aching Pain ❑ Stiffness ❑ Pressure ❑ Other _____
❑ Constant Pain ❑ Do your symptoms interfere with your daily activities? ❑ Yes ❑ No

Please locate where your symptoms are in the diagrams below.





Have you tried any of the following to treat your pain?		Did it help?	Comments
Rest	Yes ❑ No ❑	Yes ❑ No ❑	
Ice	Yes ❑ No ❑	Yes ❑ No ❑	
Heat	Yes ❑ No ❑	Yes ❑ No ❑	
Exercise	Yes ❑ No ❑	Yes ❑ No ❑	
Brace/Splint	Yes ❑ No ❑	Yes ❑ No ❑	
Physical Therapy	Yes ❑ No ❑	Yes ❑ No ❑	
Medications	Yes ❑ No ❑	Yes ❑ No ❑	
Previous Injections	Yes ❑ No ❑	Yes ❑ No ❑	
X-Ray	Yes ❑ No ❑	Yes ❑ No ❑	
MRI	Yes ❑ No ❑	Yes ❑ No ❑	
Nerve Study (EMG)	Yes ❑ No ❑	Yes ❑ No ❑	

Have you had previous neck surgery or injections in the neck? ❑ Yes ❑ No

Have you had previous hand or upper extremity surgery? ❑ Yes ❑ No

Please list previous surgeries: _____