OrthoTexas
Orthopedics & Sports Medicine

HAND / WRIST

Was this an injury or did it occur over time?____

How long have you had this problem or what was the date of your injury?______________________________

Which hand has the problem? Left / Right

Where do you have the problem? Wrist / Hand / Fingers: Thumb / Index / Long / Ring / Pinky

If an injury, describe how it occurred:____

Have you had this or a similar problem before? Yes / No

If yes, how was it treated?____

Rate your pain: No Pain 1 2 3 4 5 6 7 8 9 10 Absolute Pain

Describe your pain (circle all that apply):

Sharp	Aching	Stabbing	Dull	Constant Burn
Come and go	Pins & needles	Electric	Explosive	Unrelenting
Throbbing	Constant	Intermittent	Chronic	Unchanged
Getting better	Getting worse	Other______________________________		
Worse in the morning	Worse in the evening	Worse at night		

What makes your pain **worse**?____

What makes your pain **better**?____

Medications used for this problem:____

Have you had any tests for this problem? MRI / Bone Scan / X-ray / Other______________________________

Please indicate the location of your pain with an X:

Do you have numbness or tingling? Yes / No If yes, where?____

Do you have swelling? Yes / No If yes, where?____

Do you have popping / catching / grinding? Do you have weakness of grip? Yes / No

Do you have neck pain? Yes / No

Have you ever had any surgery on your: Hand / Wrist / Neither

Do you have any other problems not previously described? Yes / No If yes, please describe:_____________________
____

Referring Physician:____

Other Physician(s) you have seen for this problem:____

Date(s) of work/school missed for this problem:____

Is there an attorney involved with this problem? Yes / No If yes, please provide additional information:___________
____

Patient Name *(print)*:______________________________ Patient Signature:__________________ Date:_________