



The Hand Center  
OF WATERBURY



**Andrew J. Nelson, M.D.**

CERTIFIED BY THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY  
WITH ADDED QUALIFICATION IN HAND SURGERY

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CERTIFIED BY THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY  
WITH FELLOWSHIP TRAINING IN HAND AND UPPER EXTREMITY SURGERY

## What to expect from your visit

We strive to provide excellent customer service to all our patients from their first phone call to the office to their last appointment. To help us help you make your appointment a success, please bring the following to your appointment:

- insurance card,
- photo ID,
- co-pay or co-insurance payment,
- insurance referral if needed,
- copies of any other physician notes for the same problem,
- copies of nerve studies,
- copies of x-rays or imaging studies such as CT Scans or MRIs for the problem area, and
- your completed patient intake form.

For our older patients or any patient who has support or help with medical decision-making, we ask that you bring your family member or other support person with you to your appointments with our doctors.

For patients under the age of 18 (minors), please refer to our policy on the treatment of minors.

Please also be advised that in adherence to our health insurance company contracts, our office policy is to re-schedule appointments for patients who are not prepared with their copay or co-insurance at the time of the appointment.



# Update Sheet New Problem Medical Survey Form

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of last completed form: \_\_\_\_\_ Insurance has been verified:  No  Yes (Staff initials: \_\_\_\_\_)

Who is your primary care physician? \_\_\_\_\_

**UPDATE – General Information (page 1 &2):**

Has your primary doctor changed?  No  Yes – List \_\_\_\_\_  
 Has your work status changed?  No (please move to the “chief complaint”)  Yes (please complete the following questions)  
 Are you currently employed?  Yes  No  Retired  Student  
 Permanent Disability  Temporary Disability If **disabled**, for what? \_\_\_\_\_  
 Is this a work-related injury?  Yes  No  
 If working, who is your employer? \_\_\_\_\_ For how long? \_\_\_\_\_  
 Please describe your job (or former job.) \_\_\_\_\_  
 If you stopped working, when did you stop? \_\_\_\_\_

**CHIEF COMPLAINT**

Why are you seeing the doctor today? \_\_\_\_\_

On the diagrams below, please identify where your problem is:

Are you **RIGHT** or **LEFT** handed?  RIGHT  LEFT  AMBIDEXTROUS – Writes with \_\_\_\_\_ hand

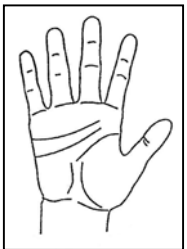
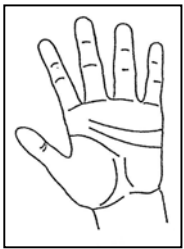
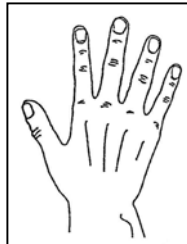
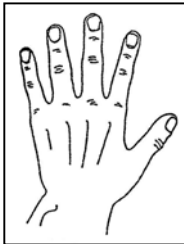
**LEFT ARM**

**LEFT HAND**

**RIGHT HAND**

**RIGHT ARM**

**Physician's Notes:**



**If both RIGHT and LEFT sides are affected, which is worse?**  RIGHT  LEFT  EQUAL

How bad is your pain – circle one number: (not bad) 1 2 3 4 5 6 7 8 9 10 (worst pain I've ever had)



Are you getting better?  Better  Worse  Staying the same for a while

**How** did your symptoms begin? \_\_\_\_\_

Have you ever had this problem or these symptoms before?  No  Yes - Describe: \_\_\_\_\_

Have you ever injured this area before?  No  Yes - Describe: \_\_\_\_\_

Have you had any **tests** for this problem?

Test	No	Yes	When?	Where?	(Staff Use)
X-Rays					
MRI					
CT Scan					
Nerve Study					
Other (list:)					

Have you seen another **Doctor** for this problem? \_\_\_\_\_

Have you had any **treatment** for this problem?

- Splints  No  Yes - Type of splint/use: \_\_\_\_\_
- Therapy  No  Yes - Where: \_\_\_\_\_ When was your last therapy visit? \_\_\_\_\_
- Medication for this problem  No  Yes - List: \_\_\_\_\_ Date last used: \_\_\_\_\_
- Other: \_\_\_\_\_

Is your pain:  constant  intermittent (comes and goes)  sharp  dull  aching  pounding  other: \_\_\_\_\_  
 associated with a particular activity? Please list: \_\_\_\_\_

If your pain is intermittent, **when** do your symptoms occur?

- night  morning  during activity  after activity
- work  cold  neck movement  other: \_\_\_\_\_

What makes your symptoms **worse**?  Not Applicable

- rest  therapy  heat  cold  brace/splint  exercise  other: \_\_\_\_\_
- work/activity – be specific: \_\_\_\_\_

What makes your symptoms **better**?  Not Applicable

- rest  therapy  heat  cold  brace/splint  exercise  other: \_\_\_\_\_
- medications – Please list: \_\_\_\_\_

Do you have pain in any other joints?  No  Yes - List: \_\_\_\_\_



**PHYSICIAN NOTES**

DATE OF INJURY: \_\_\_\_\_

X-rays taken:  No  Yes – List: \_\_\_\_\_

Work-Status Note Completed:  No  Yes \_\_\_\_\_

Prescribe Hand Therapy:  No  Yes \_\_\_\_\_

Injection Given:  No  Yes  Celestone  Kenelog \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Right**

**Left**

Hand

Hand

Thumb

Thumb

Index

Index

Middle

Middle

Ring

Ring

Small

Small

_____	PHALENS	_____	_____
_____	Wr TINEL	_____	_____
_____	ELBOW FT	_____	_____
_____	Elb TINEL	_____	_____
_____	Wr Flex	_____	_____
_____	Wr Ext	_____	_____
_____	Wr RD	_____	_____
_____	Wr UD	_____	_____
_____	GRIP	_____	_____