



The Hand Center
OF WATERBURY



Medical Survey Form 3 Year Update

Name _____ Age _____ Today's Date _____

Primary Care Physician _____ Address _____

EMPLOYMENT INFORMATION

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

When did your symptoms begin/Date of injury? _____

Why are you seeing the doctor today? _____

● Are you **RIGHT** or **LEFT** handed? RIGHT LEFT AMBIDEXTROUS - Writes with _____ hand

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

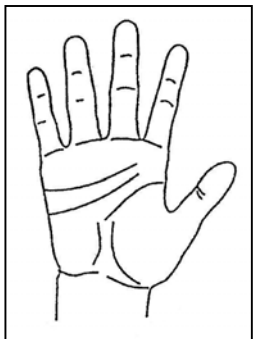
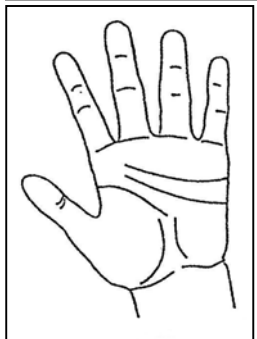
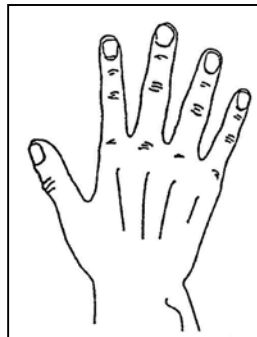
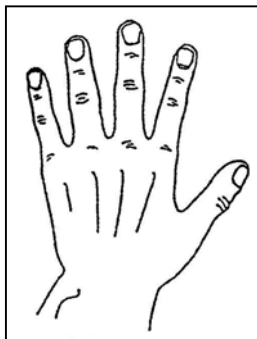
LEFT ARM

LEFT HAND

RIGHT HAND

RIGHT ARM

Physician's Notes:



PAGE 2

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? (If you are completing this at home, please bring copies of any tests to your first appt.)

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

Have you seen another **Doctor** for this problem? No Yes – List: _____

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 in your body? No Yes - List: _____

MEDICAL & FAMILY HISTORY

Please check the items that apply to you

Please check the items that apply to your family members

	Yes	No	<i>Physician's Notes</i>	Mother	Father	Sister	Brother	Grandparent
Bleeding Disorders								
Heart Problems (see below)								
Breathing Problems								
Anesthesia Problems								
Arthritis								
Broken Bones								
Stomach Problems								
Intestinal Prob's								
Allergy Problems								
Kidney Problems								
Thyroid Problems								
Neuro. Problems								
Stroke								
Cancer – what type?								
Diabetes								
Cholesterol Problems								
High Blood Pressure								
Dupytren's								
Other:								
Other:								

Do **you** have a heart problem? No Yes - please describe:

- Heart Attack (MI)
 Congestive Heart Failure (CHF)
 Stents
 Irregular Beat/Palpitations
 Murmur
 Coronary Artery Bypass Grafting (CABG)
 Mitral Valve Prolapse (MVP)
 "Water on the lung"

Have you ever had any unusual infections?

- No
 Yes:
 Tuberculosis
 Pneumonia
 Mycobacterium
 Other: _____

Have you been living with anyone in the past 2 years who has been diagnosed with Tuberculosis (TB)? No Yes

Are you experiencing peri-menopause? N/A No Yes - Did you use any medications? (circle) YES NO

Have you gone through menopause? N/A No Yes - Did you use any medications? (circle) YES NO

SURGICAL HISTORY

Please identify all the surgery that you have had. If you recall the date and doctor, please list them:

Surgery	None	Yes	Type of Surgery	Right/Left	Date/Year	Doctor
Arm or Hand Surgery						
Cardiac/Heart				NA		
Neck				NA		
Back				NA		
Knee						
Hip						
Other Orthopaedic						
Other Orthopaedic						
Tonsillectomy				NA		
Appendectomy				NA		
Gall Bladder				NA		
Breast						
Other OB-Gyn						
Hysterectomy				NA		
Prostate/Other				NA		
Laparoscopy				NA		
Other:						
Other:						

MEDICINES

Please list your current medications (both prescription & over the counter,) vitamins, aspirin, etc.
 – we will photocopy your list:

Prescription Medication	Dose/Frequency	Prescribing Doctor if other than Primary Doctor
Blood Thinning Medicine <input type="checkbox"/> Plavix <input type="checkbox"/> Coumadin		
Antibiotics – type?		
High Blood Pressure Meds		
Other:		
Other:		
Other:		
Other:		
Other:		

Non-Prescription/Herbal	Dose/Frequency	Prescribing Doctor if other than Primary Doctor
Advil/Motrin/Iburpofen		
Aleve/Naprosyn		
Aspirin		
Multi-Vitamin		
Vitamin E		
Herbal Supplements		
Other:		
Other:		
Other:		
Other:		

Do you have any **ALLERGIES** to medications? No Yes: list and describe reaction _____

What Pharmacy do you use? _____

REVIEW OF SYMPTOMS

Please check off any of these symptoms that apply to you. Please circle any symptoms that you are currently experiencing.

- 1. **General:** N/A Chills Fatigue Weight loss Weight gain Daytime sleepiness
- 2. **Neuro:** N/A Headache Weakness Passing out Numbness, tingling Stroke
- 3. **Eyes:** N/A Eye pain/pressure Vision changes
- 4. **ENT:** N/A Hearing loss Lightheadedness Sinus/Nasal congestion Sleep apnea
- 5. **Respiratory:** N/A Cough Coughing blood Wheezing Shortness of breath
- 6. **Cardiac:** N/A Chest pain Palpitations Awaken short of breath Ankle swelling
- 7. **Gastro/Intestinal:** N/A Heartburn Nausea/Vomiting Difficulty swallowing Irritable bowel
- 8. **Genito/Urinary:** N/A Frequent urination Painful urination Menopause Prostate problems
- 9. **Allergy:** N/A Environmental allergy Sneezing fits
- 10. **Heme/Lymph:** N/A Swollen glands Sweating at night Bleeding problems Easy bruising
- 11. **Endocrine:** N/A Feel warmer than others Feel cooler than others
- 12. **Musculoskeletal:** N/A Muscle aches Joint pain Joint swelling Broken bones Joint surgery Ligament laxity
- 13. **Skin:** N/A Rash Hives Itching Hair symptoms Skin changes
- 14. **Psych:** N/A Depression Anxiety Panic
- 15. To help keep our medical records complete, please provide your **current height & weight:** ____ Feet ____ Inches ____ Lbs.

Please give a short explanation for anything checked off in the Review of Systems above: _____

SOCIAL HISTORY

Marital Status: Single Married Partner Separated Divorced Widowed

Do you live alone? No Yes

Are you the primary care taker for anyone other than yourself?

No Child(ren) Adult Child Disabled Spouse Parent Other: _____

If applicable, who assists you in medical decision making? N/A _____

Do you have children? No Yes – How old are they? _____

Do you exercise? Never Rarely Daily/Weekly Monthly What type of exercise? _____

What sporting activities/hobbies do you engage in? _____

Do you smoke? No Yes – Packs per day? _____ Pipes or Cigars per day? _____ **If you stopped – how long ago?** _____

Do you use alcohol? No Yes Social

Do you have a history of substance abuse? No Yes – Describe: _____

Do you currently use a cane, walker, or wheelchair? No Yes – Describe use: _____

PATIENT'S SIGNATURE: _____	DATE: _____
-----------------------------------	--------------------

Name of the person who completed this form if not the patient: _____ Relationship: _____

For Office Use Only:

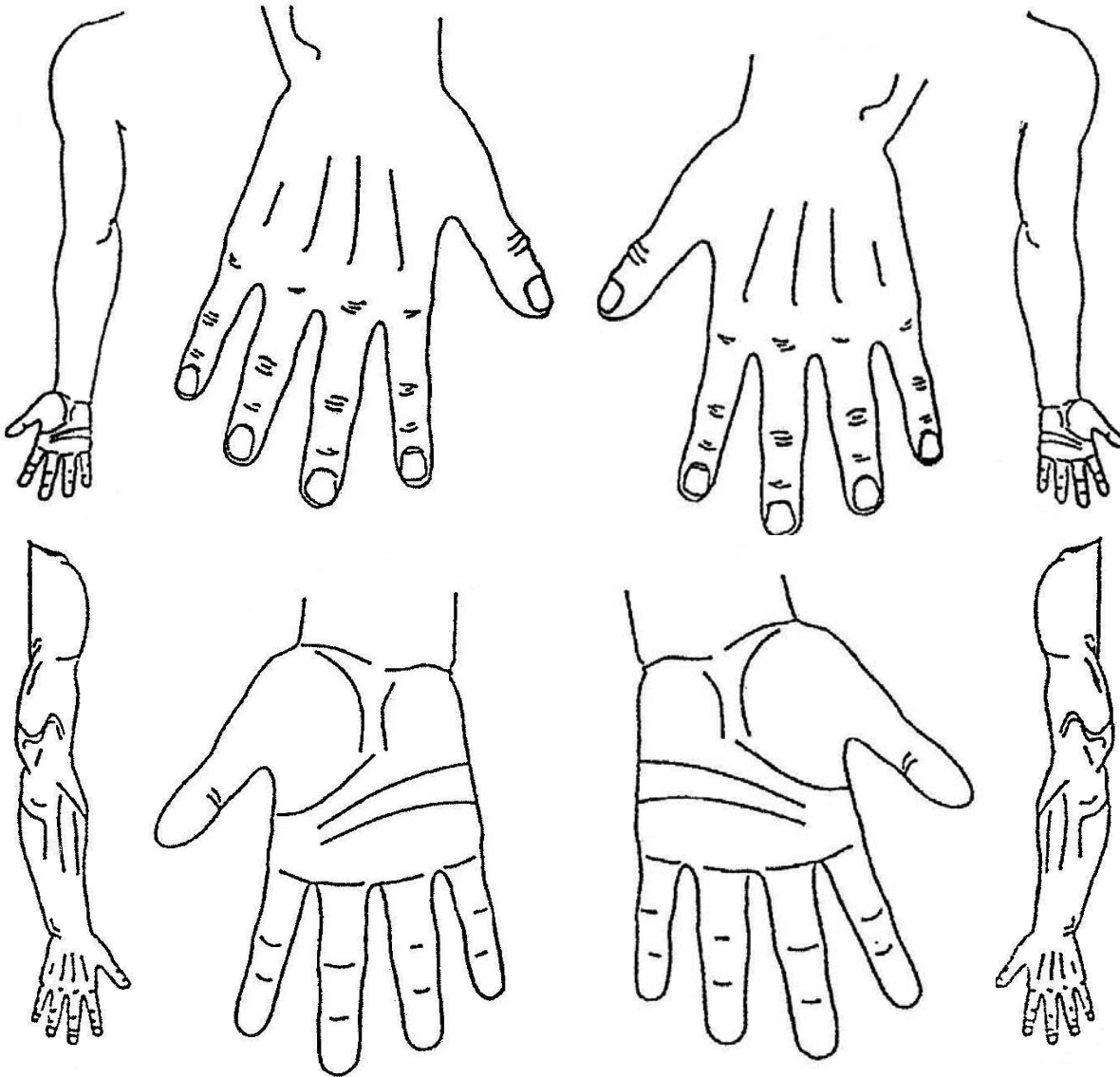
Reviewed by: _____ MD Date: _____

Respirations: _____ Normal _____ Abnormal (Comment: _____)

Pulse: _____ beats/min.

PHYSICIAN NOTES

DATE OF INJURY: _____



	<u>RIGHT</u>	<u>LEFT</u>
PHALENS		
Wr TINEL		
Thenar Atrophy		
ELBOW FT		
EIb TINEL		
1 st DI/ADQ/CLAW		
Wr Flex		
Wr Ext		
Wr RD		
WR UD		
GRIP		

X-ray

EMG's

Injection

Brace/Splint

Hand Therapy

Follow-up