HAND AND UPPER EXTREMITY

Medical History Questionnaire

Name:________________________________ DOB:__________ Age:______ Today's Date:__________

Referred by:________________________________ Primary Care Doctor:________________________________

(Please provide us with the name, mailing address & telephone number)

May we send a copy of your office note to your referring and/or primary physician? Yes No

Reason for your visit:____

How long has this been a problem?____

(Note to: location, quality, severity, duration, timing)

Which hand/arm is affected? Right Left Both

Which hand do you write with? Right Left Both

Did this injury occur at work? Yes No

Past Medical History:

Mark if you have had any problems with any of the following:

- ☐ Respiratory problems
  - ☐ Asthma
  - ☐ Bronchitis (chronic)
  - ☐ Emphysema
  - ☐ Tuberculosis
  - ☐ Pneumonia
  - ☐ Other
  - ☐ None
- ☐ Stomach/GI problems
  - ☐ Gallbladder problems
  - ☐ Ulcer disease
  - ☐ Inflammatory bowel disease
  - ☐ Hepatitis
  - ☐ Other
  - ☐ None
- ☐ Heart/Vascular Problems
  - ☐ Heart Attack
  - ☐ Chest pain
  - ☐ Arrhythmia
  - ☐ Heart failure
  - ☐ Valve abnormality
  - ☐ DVT, PE, or phlebitis
  - ☐ Other
  - ☐ None
- ☐ Urinary problems
  - ☐ Infections
  - ☐ Kidney stones
  - ☐ Pain/frequency
  - ☐ Other
  - ☐ None
- ☐ Eye/Vision problems
  - ☐ Poor vision
  - ☐ Glaucoma
  - ☐ Retina problems
  - ☐ Other
  - ☐ None
- ☐ Neurologic problems
  - ☐ Neuropathy
  - ☐ Numbness/tingling
  - ☐ Stroke
  - ☐ Seizure
  - ☐ Unsteady gait
  - ☐ Other
  - ☐ None
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Clotting disorder
- ☐ Diabetes
- ☐ Hypertension
- ☐ Thyroid disease
- ☐ Herpes Zoster
- ☐ Shingles
- ☐ Rash
- ☐ Psoriasis
- ☐ Other________________
- ☐ Other________________
- ☐ Other________________

☐ **No Past Medical Problems**

Past Surgical History: ____

Family Medical History:

Mother: ____

Father: ____

Allergies:________________________________ ☐ **No Known Drug Allergy**

Current Medications (with doses): ☐ **None**

Social History:

Occupation:______________________ Marital Status:__________ # children: ______________

Tobacco:______________________ pack(s)/day__________ # years:______________

Alcohol:______________________ drink(s)/day __________

(over ➡)

Review of Systems:

Are you currently having problems with your:

	Please circle No/Yes		Please describe all Yes responses
Eyes	No	Yes	______________________
Ears, nose, throat, mouth	No	Yes	______________________
Cardiovascular	No	Yes	______________________
Respiratory	No	Yes	______________________
Gastrointestinal	No	Yes	______________________
Genitourinary	No	Yes	______________________
Musculoskeletal	No	Yes	______________________
Skin and/or breast	No	Yes	______________________
Neurological	No	Yes	______________________
Psychiatric	No	Yes	______________________
Endocrine	No	Yes	______________________
Hematologic/lymphatic	No	Yes	______________________
Allergic/immunologic	No	Yes	______________________
Other	No	Yes	______________________

Nursing:

Ht: Wt: Temp: BP: HR: Resp:

Patient's Signature:______________________________________**Date**__________

Physician's Signature:____________________________________**Date**__________

Name:____________________

PHYSICAL EXAMINATION

General appearance: îhealthy îWD/WN îoverweight îNAD î____________

Gait: înomal îantalgic îataxic îcane-bearing îcrutch-bearing îwheelchair

Peripheral vascular: îswelling/edema îvaricosities radial pulse Rt: î2+ îregular îabsent
Lt: î2+ îregular îabsent

Lymphatic (nodes): + / - neck + / - axilla + / - epitrochlear înone in upper extremities

Neuro/Psych: îoriented x 3 înl mood & affect îanxious îagitated î____________

	Thumb	Index	Long	Ring	Small
MCP	(/)	(/)	(/)	(/)	(/)
PIP		(/)	(/)	(/)	(/)
DIP	(/)	(/)	(/)	(/)	(/)
Flex lag					
Ext lag					

Grip: ____lb/kg

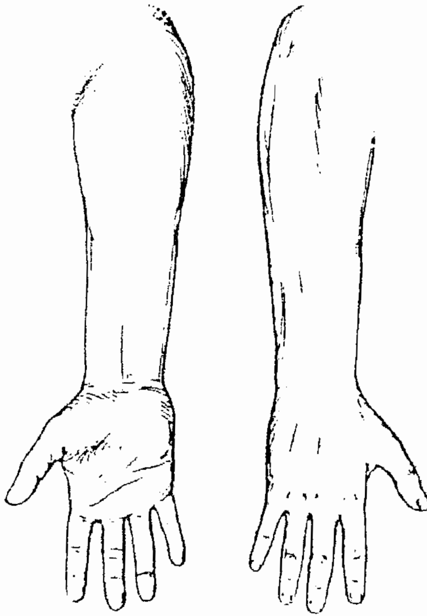
Pinch: ____lb/kg

(Right)		RANGE OF MOTION	(Left)	
Passive	Active	JOINT	Active	Passive
		Shoulder: FF		
		Abd		
		IR		
		ER		
		Elbow: Flex		
		Ext		
		Pron		
		Supin		
		Wrist: Flex		
		Ext		
		Rad dev		
		Uln dev		
		Thumb: Rad abd		
		Palm abd		

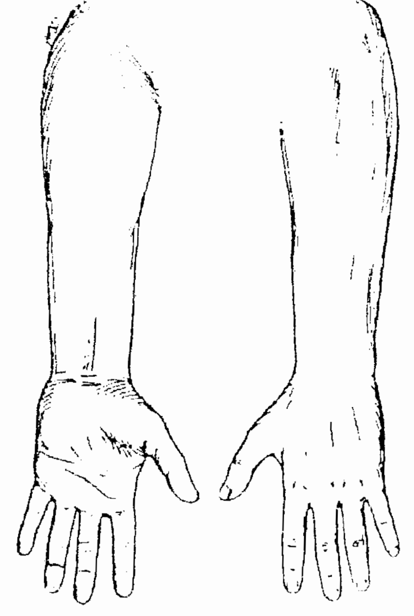
	Thumb	Index	Long	Ring	Small
MCP	(/)	(/)	(/)	(/)	(/)
PIP		(/)	(/)	(/)	(/)
DIP	(/)	(/)	(/)	(/)	(/)
Flex lag					
Ext lag					

Grip: ____lb/kg

Pinch: ____lb/kg



RIGHT



LEFT

X-ray Findings:____

Impression:____

Plan:____

Physician Signature:____________________ Date:______________