Orthopedic Patient Questionnaire: WRIST & HAND

Name: _____ Gender: ☐ Male ☐ Female

1. What are you having problems with? ☐ Wrist ☐ Hand Finger(s): ☐ Thumb ☐ Index ☐ Long ☐ Ring ☐ Little

2. Which wrist / hand is bothering you? ☐ Right ☐ Left ☐ Both | Which hurts worse: ☐ Right ☐ Left

3. When did your symptoms begin? (month/day/year) _____ *OR*
   Estimate how long you have had your symptoms: _____ month(s) or _____ year(s)

4. Were you injured? ☐ Yes ☐ No How were you injured? _____
   Where: ☐ Work ☐ Home ☐ Other: _____

5. Prior injuries or problems to your wrist/hand? ☐ Yes ☐ No When: _____
   How were you injured? _____
   Who treated you? _____

6. Prior treatment for this injury? ☐ None ☐ Emergency Room | Hospital: _____
   ☐ Doctor's office | Name: _____

7. What was done? X-rays: ☐ Regular x-rays ☐ MRI/CT Scan ☐ Bone Scan ☐ Athrogram ☐ EMG/NCV
   Medication: ☐ Anti-inflammatory ☐ Pain medicine ☐ Cortisone shot
   Devices: ☐ Finger splint ☐ Wrist splint (Velcro / plastic / plaster / fiberglass)
   Cast: ☐ Long arm (above the elbow) ☐ Short arm (below the elbow) ☐ SATS
   Physical therapy: ☐ Yes ☐ No If yes, how long? _____

8. Prior surgery to this area? ☐ None ☐ Yes: ☐ Fracture (pins / plate / screws / fixator) ☐ Carpal tunnel release
   ☐ Tendon repair ☐ deQuervqain's release ☐ Nerve repair ☐ Amputation

9.	Pain	Time of Day	General	Prior
Wrist / Hand	☐ Constant / ☐ Comes & goes ☐ Only with motion of the wrist ☐ Even without motion	☐ Worse first thing in the morning ☐ Worse during the day (with use) ☐ Worse at night	☐ Tenderness ☐ Cyst or bump	☐ Fracture (broken wrist) ☐ Electrical test (EMG/NCV) ☐ Diagnosis of Carpal Tunnel
Finger(s): Thumb Index Long Ring Little	☐ Constant / ☐ Comes & goes ☐ Only with motion of the wrist ☐ Even without motion	☐ Worse first thing in the morning ☐ Worse during the day (with use) ☐ Worse at night	☐ Tenderness ☐ Cyst or bump	☐ Fracture (broken wrist) ☐ Amputation ☐ Finger locks
Neck	☐ I have no neck pain	☐ I have neck pain		

MAGAN MEDICAL CLINIC
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PATIENT LABEL

REV [08/2008]
FORM 392

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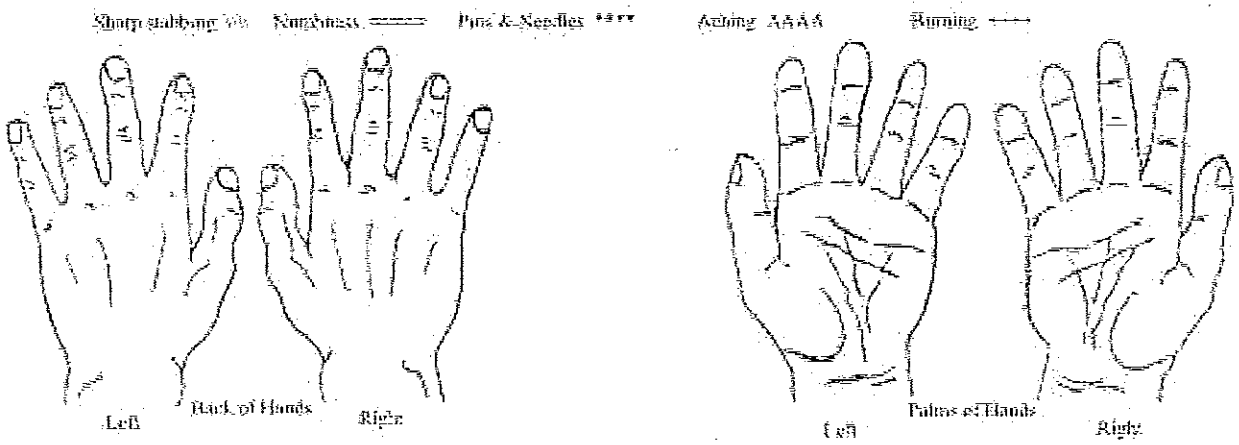
10. Draw on the hand diagrams all areas where you feel pain or a change of sensation. (Please use black ink.)
    Pain and sensation are different, so use the different symbols as listed below.
    Sensation type:



Please return to receptionist when complete.

Patient Signature

Date

If other than the patient, indicate relationship

M.D./P.A.

Provider Signature

PATIENT LABEL