



HAND QUESTIONNAIRE

Today's Date _____ First Name _____ Last Name _____
 Date of Birth _____ Age _____ Occupation _____ Gender: Male Female
 Height _____ Weight _____

HISTORY

Handedness: Right Left Which hand is causing concern? Right Left If both, which is worse? Right Left
 What is the main problem that brought you to see the doctor today? _____

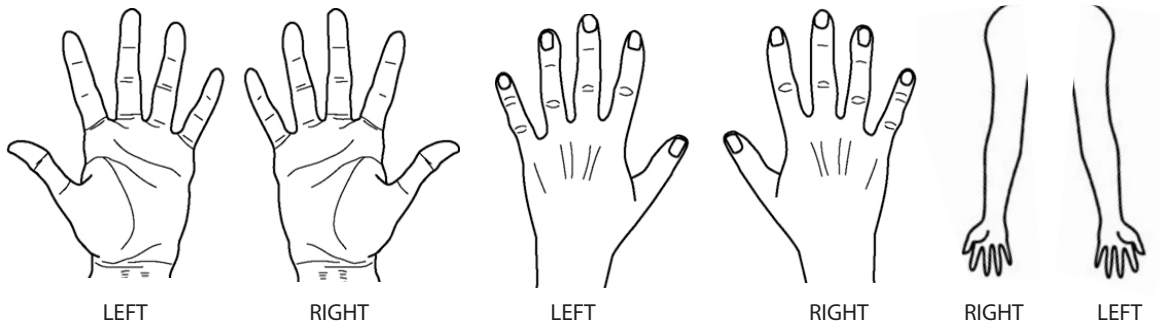
How long have you had symptoms or when were you first injured? Please list the exact date, if possible. _____
 Is this a work-related injury? Yes No Employer: _____

Please rank the severity of your symptoms: Mild Moderate Severe Duration: On and off Constant
 Describe your quality of pain: Dull Throbbing Sharp Burning Numbness Tingling Ache Other: _____

Please list any hobbies, sports or special uses of your hands: _____

Please shade in the diagrams at right to show problem areas:

- Pain
- Tingling
- Numbness
- Decreased Sensation
- Cut or Laceration
- Mass, Ganglion, or Bump



TREATMENT & MEDICATIONS

What makes your symptoms better? _____
 What makes your symptoms worse? _____

Please list any prior treatment you have had for this problem, and whether it has helped.

- Medications (type): _____
- Splints (type, wear day/night/both): _____
- Injections (dates, exact location): _____
- Surgery (dates/description): _____
- Other: _____

If a healthcare provider sent you to this clinic today, please list their name: _____

Patients of Melissa Fagan, ARNP, please complete reverse side.

FOR DOCTOR USE ONLY



NEUROPATHY QUESTIONNAIRE (Patients of Melissa Fagan only.)

If you have numbness or tingling in the arm(s) or hand(s), carpal tunnel, or other nerve problem affecting the hands, please continue below.

Which part(s) of the body are bothering you?

- Thumb Head Elbow Leg
- Index Finger Neck Wrist Feet
- Middle Finger Chest Whole arm to the shoulder
- Ring Finger Back Elbow to finger tip
- Small Finger Shoulder Wrist to finger tip

On a scale of 1 to 10, where 1 represents no pain or discomfort, and 10 represents the worse pain you have experienced, how would you rate your current problem. (Please circle only one number.)

1 2 3 4 5 6 7 8 9 10
No Pain ←—————→ Moderate Pain ←—————→ Severe Pain

Please place a check (✓) in the appropriate spot to indicate the level of difficulty you are having for each activity listed below:

	No Difficulty	Moderate Difficulty	Severe Difficulty		No Difficulty	Moderate Difficulty	Severe Difficulty
Writing legibly	_____1	_____2	_____3	Bathing and dressing	_____1	_____2	_____3
Holding a book or newspaper	_____1	_____2	_____3	Turning keys	_____1	_____2	_____3
Talking on the phone	_____1	_____2	_____3	Using tools	_____1	_____2	_____3
Household chores	_____1	_____2	_____3	Driving	_____1	_____2	_____3
Carrying grocery bags	_____1	_____2	_____3				

If work related, how is it work related?

- Repetitive hand use Use of wrenches Hammering Injury: _____
- Forceful gripping Forceful pinching Frequent heavy lifting _____

Have you have been on restricted or light work? Yes No When did it begin? _____

If you returned to work after being off for medical reasons, when did you return? _____

How often do you have hand or wrist pain during the day? Never 1-2 times per day 3-5 times per day The pain is constant

How long (on average) does an episode of daytime pain last? No daytime pain Less than 10 minutes More than 60 minutes The pain is constant

How severe is the hand or wrist pain? No pain Mild pain Moderate pain Severe pain

How often does hand or wrist pain, numbness, or tingling wake you up during a typical night? Never 1 2-3 More than 5

How severe is numbness (loss of sensation) or tingling in your hand?

Daytime: None Mild Moderate Severe Nighttime: None Mild Moderate Severe

How much of the time are your hands numb and/or tingly? Never 25-50% of the time More than 50% of the time 100% of the time

Please check conditions you have:

- Yes No Diabetes Yes No Raynaud's Disease Yes No Lupus Yes No Kidney disorder
- Yes No Rheumatoid Arthritis Yes No Thyroid Problem Yes No Changes in color of fingers Yes No Scleroderma

Other: _____

Is there anything else you would like to add? _____

Who filled out this form? Self Family/Friend Nurse

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____