PHYSICIANS' CLINIC
of Iowa, P.C.

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

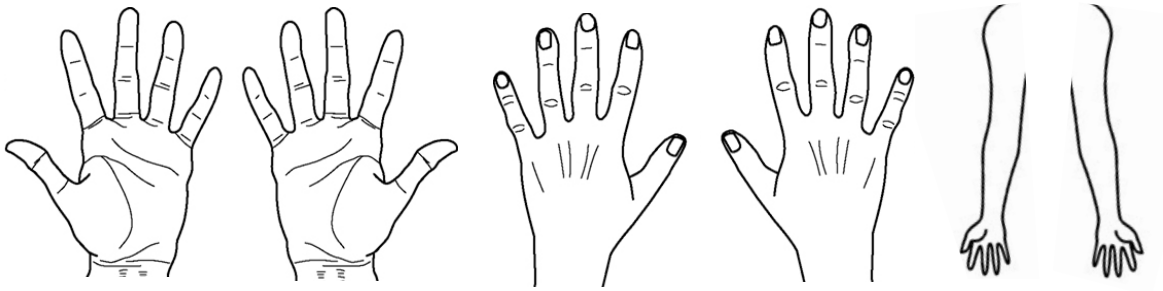
Tingling

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: _____

Boxed section is for provider documentation.

NEUROPATHY QUESTIONNAIRE

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: _____

This form is destroyed after the information is entered and verified in the patient's electronic health record.