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: ____

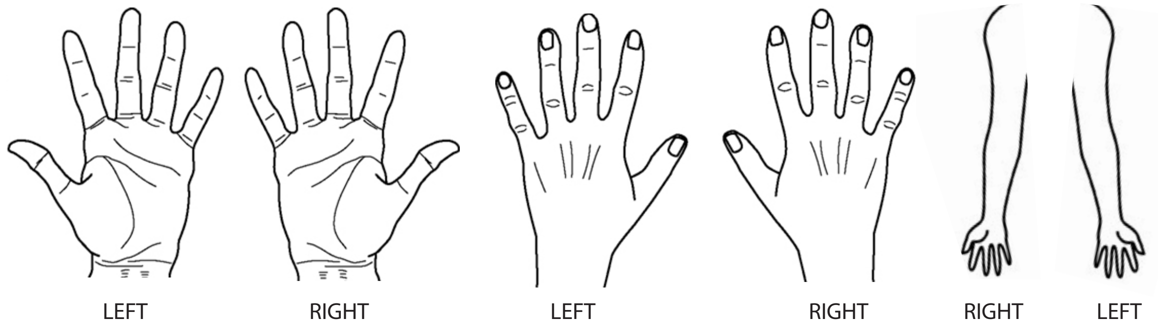
Please rank the severity of your symptoms: ☐ Mild ☐ Moderate ☐ Severe Duration: ☐ On and off ☐ Constant

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: ____

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: ______________

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