Hand Worksheet - Patient

Date _____/_____/_____
Name _____Medical Record #_____
Age _____
Occupation_____
Dominant Hand **RIGHT** **LEFT** **AMBIDEXTEROUS**

Describe the problem you are having with you hand or arm from original onset until now.

_____
_____
_____
_____
_____

List all previous hand & arm surgeries (include dates and side)

_____
_____
_____

List all NON-surgical treatment have you undergone for your hand problem.

_____
_____
_____

Has anyone made specific recommendations regarding your hand? Yes No
What are these recommendations?

_____
_____
_____

Do you have any other hand problems

- ❑ Pain
- ❑ Numbness
- ❑ Stiffness
- ❑ Loss of Movement
- ❑ Lumps
- ❑ Growths
- ❑ Lacerations
- ❑ Fractures
- ❑ Infections
- ❑ Contractures
- ❑ Scars
- ❑ Burns
- ❑ Open Wounds
- ❑ Amputations
- ❑ Tendon Injuries
- ❑ Nerve Injuries
- ❑ Circulation Problems

Other_____
_____
Do you form keloids or severe scars Yes / No
Where_____
Please list **ALL** medical problems:

_____
_____

Please list **ALL** medications. (List Medication, Dose, & Frequency):

_____
_____
_____
_____

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Do you take or have you ever taken in the last month any vitamins, homeopathic medicines, herbs or herbal medicines, botanicals, etc., including echinacea, ephedra (mahuang), garlic, ginko, ginseng, kava, St. John's Wort, or valerian? *(All herbal medicines must be stopped at least 2 weeks before the date of surgery.)* ☐ No If yes, please list.

_____

Have you ever taken cortisone or steroids? Yes / No What, When, How, Why and How Long?

_____

Have you ever taken any type of hormones, including birth control? What, When, Why and How Long?

_____

_____

Please list **ALL** other surgeries:

_____

_____

Habits

Tobacco use Yes No Type_____ Amount & Duration _____Quit when?_____
Alcohol use Yes No Type_____ Amount & Duration _____
Drug use Yes No Type_____ Amount & Duration _____

Allergies	**Drug/Food/Allergen**	**Type of Reaction**
	_____	_____
	_____	_____
	_____	_____
	_____	_____