NAME: MR #: VISIT DATE:

PLEASE ANSWER QUESTIONS IN THIS COLUMN

Phone (Home) #_______________(Cell)#_____________

Age : _____ Occupation: ___________________

Circle handedness: Right Left Ambidextrous

Circle marital status: Married Single Divorced Widowed

CURRENT HAND, WRIST, or UPPER EXTREMITY COMPLAINT(S) ?

Are You in PAIN ? Yes No

PAIN INTENSITY ? Circle 1 2 3 4 5 6 7 8 9 10

Describe complaints: ___________________________

When Problem Started?___________________________

How Problem Started?___________________________

Are you working ? Yes No

Work Comp Case? Yes No : No Fault ? Yes No

Are your complaints getting: Better__Worse__Staying Same__

Treatment to Date:___________________________

PAST HISTORY: Operations:_____________________

Medical Illnesses:___________________________

Drug Allergies:________________Latex Allergy: Yes No

Medications:___________________________

Aspirin: Yes No Blood Thinner: Yes No

FAMILY HISTORY: Diabetes: Yes__No__; Heart Dis:Yes__No__

Bleeding Disorder: Yes__No__; Anesthesia reaction: Yes__No__

Cancer: Yes__No__ ; Dupuytren's Disease: Yes__No__

Who in family if Yes?___________________________

SOCIAL HISTORY: Smoke: Yes__ No__ If Yes, Pack/Day_____

Drink Alcohol: Yes__No__ Amount per week?____________

Hobbies, sports etc. ___________________________

REVIEW of SYSTEMS: Do you have or take medicine for : Circle correct answer.

Stomach Problem: Yes No Arthritis: Yes No

Thyroid Disease: Yes No Heart Disease: Yes No

Weight Loss: Yes No Bladder/Prostate Problem: Yes No

Neck Injury: Yes No Neck Arthritis/Disk: Yes No

Seizures: Yes No Bowel Disease: Yes No

Hypertension: Yes No High Cholesterol: Yes No

Diabetes: Yes No Gout: Yes No Cancer: Yes No

REVIEW of SYSTEMS: Do you have complaints related to :

Head: Yes No Eyes: Yes No Ears: Yes No

Nose: Yes No Throat: Yes No Heart: Yes No

Lungs: Yes No Abdomen: Yes No Kidney: Yes No

Appetite: Yes No Joints: Yes No Other ____________

Referring Doctor:___________________________

Address:(Required)___________________________

PCP MD:___________________________

Address:Required)___________________________

Patient Name:___________________________

Additional History Review Points: (+,- or blank)

Locking Digits __ ; Trauma __; Numbness__ ; Night Sx's___

Neck __ ; XS Drop __; Driving Sx's __; Fine Motor __; DM__

Thyroid__ ; Weakness __;Dups Fx __; Seizures __;Peyronie's __

Foot Lumps __ ; Stiffness__ ; Wrist Click __ ; Mass __ ;

Enlarging __; Fluctuating Size __ ; Night Pain__ ; Wt. Loss__

Other___________________________

Examination Notes

Sensation: Right: Med - N AbN; Uln - N AbN; Rad - N AbN
Left: Med - N AbN; Uln - N AbN; Rad - N AbN

Tinel Med R__ L__Tinel Ulnar (E) R__ L__Tinel Uln(G) R__ L__

Comp Test R__ L__Phalen Test R__ L__Ulnar Flex Test R__ L__

Thenar Atrophy R__ L__ ; 1st D Atrophy R__ L__

Thenar Strength R__ L__ ; 1st D Strength R__ L__

Finkelstein R__ L__ ; Thumb CMC R__ L__

Trigger I R__ L__ ; Trigger II R__ L__; Trigger III R__L__

Trigger IV R__ L__ ; Trigger V R__ L__

Scaphoid R__ L__ ; S-L R__ L__; Watson R__L__

Lunate R__ L__ ; T-L R__ L__; Shuck R__L__

TFCC R__ L__ ; McMurray R__ L__; ECU R__L__ P-T R__L__

Hook Hamate R__ L__ ; FCR R__ L__; FCU R__L__

ROM: R L

Other:

Xray(Imaging)___________________________

Ultrasound___________________________

Diagnoses___________________________

Plan___________________________

Consult Request:_____________

Return to Work or Gym Date

Xiaflex: Get Drug: Single Dose ___ Double Dose ____

Circle **Right**: I, II, III, IV, V ; **Left**: I, II, III, IV, V & MP PIP DIP

ASC Yes__No__ ; **Clearance** Yes__No__; **Anticoag** Yes__No__

Schedule Surgery: Procedure___________________________

ASC Yes__No__ ; **R**___**L**___**; Anticoag** Yes__No__

Clearance Yes__No__; **Clearance** by Who?______________

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Version 08 13 2020