NEW PATIENT INFORMATION SHEET
Orthopedic Hand and Upper Extremity Patients

Name_____Today's Date_____

What concern brings you in today?_____
Who referred you to this office?_____

Please help us understand more about your symptoms.

1. Location: Is your problem on the right [ ] or [ ] left?
[ ] Shoulder [ ] Elbow [ ] Wrist [ ] Hand [ ] Thumb
[ ] Index Finger [ ] Middle Finger [ ] Small Finger [ ] Ring Finger

2. Timing: When did this start? Date_____/_____/_____
Please describe if an accident or other activity brought this on:

Do your symptoms occur with [ ] exercise [ ] work [ ] at night [ ] in the morning

3. Quality:
Describe your symptoms: [ ] popping/catching [ ] sharp [ ] throbbing [ ] burning

4. Associated Symptoms:
Do you have any of the following symptoms and if so where do you have them?
[ ] Bruising_____ [ ] Swelling_____ [ ] Redness_____
[ ] Numbness_____ [ ] Tingling_____ [ ] Weakness_____

5. Modifying Factors: What makes your symptoms better?
[ ] Rest [ ] Splints [ ] Ice [ ] Medication (Ibuprofen, Vicodin, etc.?)

If you have been treated for this previously please describe in detail
_____
_____

What makes your symptoms worse?
_____
_____

6. Severity: How would you rate your pain on a scale of 0 (no pain) to 10 (worst pain)?
When the pain is at its worst_____ Over the course of the day_____ Now_____

7. Duration: Are your symptoms [ ] constant [ ] intermittent?

8. Context: Over all are symptoms [ ] improving [ ] worsening [ ] unchanged [ ] other?

General Information: Age_____ Are you [ ] right handed or [ ] left handed?
What exercise/sports do you engage in regularly? _____

Please see second page →

Review of Systems: Do you have any problems with?

1. Constitutional/ General: [ ] Weight Loss [ ] Weight Gain [ ] Excess Fatigue [ ] Fever/Chills
2. ENT/Mouth: [ ] Current Cavities [ ] Bleeding Gums [ ]Hearing Loss [ ] Tinnitus
3. Cardiovascular: [ ] Chest Pain [ ] Palpitations
4. Respiratory: [ ] Shortness of Breath [ ] Wheezing [ ] Cough
5. Gastrointestinal: [ ] Heartburn/Reflux [ ] Nausea [ ] Vomiting [ ] Constipation [ ] Diarrhea
6. Musculo/Skeletal: [ ] Joint Pain [ ] Joint Stiffness [ ] Joint Deformity [ ] Joint Swelling
7. Skin: [ ] Rashes [ ] Changing Skin Lesions [ ] Poor Healing [ ] Itching [ ] Redness
8. Neurologic: [ ] Tremor [ ] Fainting [ ] Difficulty with Coordination [ ] Memory Loss
9. Psychiatric: [ ] Nervousness [ ] Anxiety [ ] Depression [ ] Mania [ ] Halluncinations
10. Hematologic: [ ] Easy Bruising/Bleeding [ ] Swollen Glands in Neck or Groin

Past Medical History

Are your medical records in the PAMF computer system? [ ] yes or [ ] no
The following is a list of significant medical problems that may affect your medical care.
Even if your records are in the computer, please let us know if you have any of the following or any other significant medical problems.

[ ] High Blood Pressure [ ] Heart Disease/Attack/Arrhythmia [ ] Pacemaker or AICD
[ ] Stroke of CVA [ ] Seizures
[ ] Diabetes Type 2 [ ] Diabetes Type 1 [ ] Use Insulin Pump [ ] Thyroid Disorder
[ ] Osteoarthritis [ ] Rheumatoid Arthritis [ ] other Arthritis [ ] Gout
[ ] Asthma [ ] Emphysema/COPD
[ ] Liver Disease (Hepatitis, Jaundice)_____[ ] Immune System Disorder
[ ] History of Cancer_____
[ ] Stomach Ulcers [ ] Reflux/Heartburn
[ ] Personal or Family History of Problems with Anesthesia
[ ] Bleeding Disorder/Anemia [ ] Recurrent Infections
[ ] Depression [ ] Bipolar Disorder [ ] Other Psychiatric Disorder

Please list previous surgeries and indicate year

_____
_____
_____

Please list medications that you take on a regular basis. [ ] In PAMF computer records

_____
_____
_____

Please list any allergies to medication? [ ] none_____
Are you allergic to [ ] Latex [ ] Iodine [ ] Shellfish [ ] Eggs?

Social History

What is your occupation?_____
With whom do you live?_____
Tobacco: [ ] Never [ ]_____packs per day [ ] Quit_____years ago
Alcohol: [ ] Never [ ] Rarely [ ] Occasionally [ ] Daily_____drinks per day