Orthopaedic Institute of Southern Illinois

Dr. Steven Young, MD

HAND QUESTIONNAIRE

Name: ______________________  Age: ______  Height: ______  Weight: ______

Referring Physician: __________________ Are you Right or Left handed? (Circle)

What are you being seen for today? ________________________________

Do you have Neck, Shoulder, Elbow or Forearm pain? ____________ If Yes, describe in detail:
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

How long have you had the symptoms for which you are being seen today? ______________

In the last 5 years, have you had any treatment on the same body part you are being evaluated for today?________________ If yes, please explain in DETAIL what treatment you have had:
   ______________________________________________________________________
   ______________________________________________________________________

In regards to your present symptoms, circle all that apply:

Pain  Numbness/Tingling  Stiffness  Weakness

Which hand is involved?  Left  Right  BOTH

If both hands are involved, which is the worse?  Left  Right  BOTH

Which fingers experience numbness and tingling?  Please circle all involved:

Right Hand:  None  Thumb  Index  Long  Ring  Small

Left Hand:  None  Thumb  Index  Long  Ring  Small

Revised 11/1/12 AF
Is there a part of the day in which your symptoms are worse? ____________________________

If so, when? ____________________________________________________________

What makes your symptoms better? __________________________________________

Have you tried any of the following? (Please circle)

Anti-inflammatory       Steroid pills       Steroid injections
Splints or braces       Physical Therapy    Surgery

**MEDICAL/SOCIAL HISTORY**

Have you been diagnosed with any of the following? (Please circle)

Diabetes        Thyroid Disease        Rheumatoid Arthritis       Stroke       Depression       Fibromyalgia

Do you use Tobacco? _______ If yes, how much and for how long? ________________

Do you use Alcohol? ________ If yes, how much and for how long? ________________

Have you filed a worker’s compensation claim for this issue? ______________________

Have you filed a worker’s compensation claim in the past for ANY work injury - NOT JUST THIS BODY PART? ________________________________

If yes, what parts of the body where involved? Please provide a VERY DETAILED EXPLANATION:

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

**EMPLOYMENT HISTORY**

1. Are you currently employed? ________ How long have you been employed? __________

2. What is the name of your present or most recent place of employment?

__________________________________________________________________________

3. How long have you been employed at your current or most recent job?

__________________________________________________________________________

4. Where did you work prior to your current place of employment? _________________
5. How long did you work with this employer? ________________________________

6. What is your job title? __________________________ How long have you been performing your present job duties? ________________________________

7. Please provide an IN-DEPTH description of your job duties starting at the beginning of your work day, including each responsibility. Give each job duty a Percentage (out of 100%) of your work day that you perform that duty.

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<th>Specific Job Duty</th>
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8. Out of the job duties above, are there any that aggravate your symptoms? __________________________

If so, please list in order of severity:

__________________________________________________________________________________________

__________________________________________________________________________________________

9. What is your work schedule? (Hours per day, number of days per week): __________________________

10. Are your current symptoms increased while at work? __________________________ If so, please explain:

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

11. If your symptoms are increased while at work, how long does it take after you start work for it to become noticeable? ________________________________

12. Please provide us with a list of your hobbies.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Revised 11/1/12 AF