

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

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.

<u>Specific Job Duty:</u>	<u>Percentage (%)</u>
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____
8. _____	8. _____

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.

