Dr. Gluck Name:_____

New Patient Wrist/Hand Questionnaire

MRN:_____ (for office use)

New patients and patients arriving for new problems need to arrive 15 minutes before their scheduled appointment time. If you are not early the appointment will be rescheduled.

1. **Hand Dominance:** Right Left Ambidextrous

2. Married Single Divorced Widowed

3. Who is with you at your appointment today?
   None / Spouse / Mother / Father / Son / Daughter / Boyfriend/ Girlfriend

   Friend / Sister / Brother / Other: _____

4. Who recommended you to see Dr. Gluck: _____

5. Family Doctor: _____

6. **Work History:** Are you working: NO YES
   If NO, are you on disability? NO YES
   IF YES, what medical condition causes your disability: _____

   Employer: _____ Date Started: _____

   Job Title: _____

   Job Activity: (describe): _____

   How does wrist/hand problem effect job performance:
   ___ No restriction to employment—performing regular job
   ___ Have to adjust activity (describe): _____
   ___ Working with restrictions (describe job restrictions):_____
   ___ Unable to work

   Do you feel that your wrist/hand problem is due to work? NO YES Not Applicable

   Have you made a Work Claim for this problem? NO YES Not Applicable

7. **Hobbies:**
   Sports: (list) : _____
   Other: (list): _____

   Does the wrist/hand problem affect these activities? YES NO

8. **When did symptoms/injury happen?** (exact date, month, or year): _____

9. **Wrist/Hand Involved:** Right Left Both Which is worse: Right Left Both Equal

10. **Previous Tests**

X-rays	NO YES	When? _____	Where? _____	
MRI	NO YES	When? _____	Where? _____	
Bone Scan	NO YES	When? _____	Where? _____	
Nerve Test	NO YES	When? _____	Where? _____	
Blood Tests	NO YES	When? _____	Where? _____	

(Scan: MD Specific Forms)

11. **Previous Treatment (if applicable)**

Medication (including non prescription):	NO	YES	name: _____	Helpful?	NO	YES
Occupational/Physical Therapy	NO	YES	where: _____	Helpful?	NO	YES
Chiropractic/Acupuncture	NO	YES	where: _____	Helpful?	NO	YES
Injection	NO	YES	when: _____ by:_____	Helpful?	NO	YES
Splint/Brace	NO	YES	when: _____ by:_____	Helpful?	NO	YES
Surgery	NO	YES	when: _____ by:_____	Helpful?	NO	YES
Sutures (If injury)	NO	YES	where: _____			
Fracture or Joint Reduction /Manipulation (If injury)	NO	YES	where: _____			

12. **Chief Complaints (Circle all that Apply): Pain Limited Motion Weakness Popping Numbness**

13. **Symptoms Description:** (Circle all that Apply)

Pain Intensity: (0=no pain, 10=worst possible pain):
At its Best____ At its Worst_____ At rest_____ With Activity_____

Character: sharp & stabbing/ dull ache/ burning / throbbing/ other: _____

Duration: constant/ intermittent/ only with activity/ only at night/ other: _____

Limited Motion
Motion limited by (circle only one): pain/ strength loss/ mechanical block

Popping:	Forearm / Wrist	Fingers: Thumb / Index / Middle / Ring / Little
Numbness	Forearm / Wrist	Fingers: Thumb / Index / Middle / Ring / Little

14. **Exacerbating Activity** (activities that worsen the symptoms):

Pushing or Pulling / Lifting / Grasping / Writing / Sports Activity
Other: (describe) _____

15. **Relieving Activity** (activities that improve the symptoms):

Heat / Ice / Massage / Avoiding Activities / Brace / Medication
Other: (describe) _____

16. **Does Wrist/Hand Affect Sleep?** NO YES

If yes, (circle the following): prevents getting to sleep/ awakens at night
Frequency: every night/ ___ times a week / month

(Scan: MD Specific Forms)

17. If Injury, Where Did the Injury Occur: home / work / auto

store, name _____

other _____

18. How Did the Injury Occur: _____

19. List All Areas Injured:

1. _____ 4._____
2. _____ 5._____
3. _____ 6._____

20. **Previous Treatment?** NO
YES, Where?: _____

When (date): _____

21. **Treatment Received**

Medication (including non prescription):	NO	YES	name: _____	Helpful? NO YES
Fracture or Joint Reduction/Manipulation:	NO	YES	where: _____	
Sutures:	NO	YES	where: _____	
Splint or Brace	NO	YES	where: _____	
Surgery	NO	YES	when: ____ by: _____	

22. **Other Current Orthopaedic Conditions:**

Neck NO YES : who is providing treatment? _____
Shoulder NO YES : who is providing treatment? _____
Wrist/Hand NO YES : who is providing treatment? _____
Back NO YES : who is providing treatment? _____
Hip Knee NO YES : who is providing treatment? _____
Ankle/Foot NO YES : who is providing treatment? _____

23. **Pending Litigation?** NO YES Attorney: _____

24. What Orthopaedic Treatment are You Expecting or Told to Expect?

____Medication ____Therapy ____X-rays ____Surgery
____Cast/Splint ____Injection ____MRI

25. Describe What Outcome or Change in Your Symptoms Has to Occur for You to Consider Treatment Successful?

_____

26. Any Other Information that You Think is Important for Us to Know to Maximize Outcome for Your Hand:

_____