Name:

DOB:

OrthoCincy

Date:

Hand Evaluation

Who is your primary care physician? _____ Who is your referring physician? _____

Are You? ☐ Right Handed ☐ Left Handed

Why are you here today? RIGHT / LEFT _____

Describe how it happened and what activity you were doing: _____

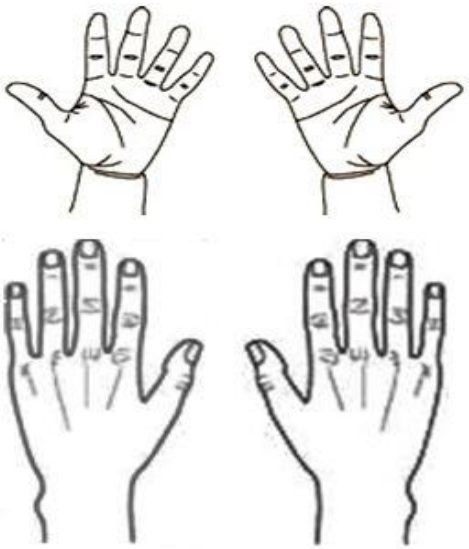
☐ **No specific injury/chronic problem**
☐ Fall
☐ Sports Injury
☐ Altercation / Fight
☐ Auto Accident--Seat Belt? ☐ yes ☐ no

Describe where you were:
☐ Home ☐ School
☐ Work ☐ Sports field/court
☐ Other: _____

The date the symptoms began: _____
☐ ____ Weeks ago
☐ ____ Months ago
☐ ____ Years ago

On this diagram mark where your pain is:

Left *Right*



Check what **BEST** applies:

The pain is:
☐ RARE
☐ INTERMITTENT
☐ CONSTANT

The pain is:
☐ DULL
☐ SHARP
☐ ACHY
☐ BURNING

Check **ALL** that apply:
☐ CATCHING/LOCKING
☐ POPPING
☐ NUMBNESS
☐ TINGLING
☐ WEAKNESS
☐ INSTABILITY
☐ SWELLING

What is your pain scale: 0 1 2 3 4 5 6 7 8 9 10
0 = no pain 10 = worst pain

Does the pain radiate anywhere? ☐ yes ☐ no

Does anything else hurt?
☐ Neck
☐ Shoulder
☐ Elbow

Testing
☐ **NONE**
☐ X-Rays
☐ CT Scan
☐ MRI
☐ Nerve Test (EMG/NCS)
☐ Lab/Blood work
☐ Other _____

Treatment
☐ **NONE**
☐ Medications:
Anti-Inflammatories
Pain Meds
Antibiotics
☐ Injections
☐ Splints / Braces
☐ Physical / Hand Therapy
☐ Surgery _____
☐ Other: _____

Where
☐ ER (St. Elizabeth / other)
☐ OC After Hours Injury Clinic
☐ Urgent Care
☐ St. E Business Health/Concentra
☐ Family PCP
☐ Orthopaedic Surgeon _____
☐ Hand Surgeon _____
☐ Specialist _____
☐ Other: _____

Patient Signature: _____

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