The Annapolis Hand Center
Patient Problem Form

Name_____ **Today's Date** ____/____/____

☐ **New Patient** ☐**Established Patient with New Problem** ☐**Follow-up visit**

Hand Dominance: ☐ **right** ☐**left**

Symptoms/ Presenting Problems_____

Date of Onset_____ **Injury occurred at** ☐**work** ☐**home** ☐ **MVA** ☐ **other**_____

Location of Problem: ☐ **right** ☐**left** ☐**both**

☐**shoulder** ☐**arm** ☐**elbow** ☐**forearm** ☐**wrist** ☐**hand**

☐**finger/fingers:** ☐**thumb** ☐**index** ☐**middle** ☐**ring** ☐**little**

P **Rating (no pain)** ☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** ☐**7** ☐**8** ☐**9** ☐**10 (most severe)**

A **Type**(check all that apply)☐**constant** ☐**intermittent** ☐**dull** ☐**sharp** ☐**throbbing** ☐**burning**

I **Worse with:** ☐**movement** ☐**lifting** ☐**gripping** ☐**throwing** ☐**pressure**

N **Improved with:** ☐**rest** ☐**exercise** ☐**brace/splint** ☐**medication** _____

Does the pain affect your ability to sleep at night? ☐**yes** ☐**no**

Other Symptoms: ☐**locking** ☐**popping** ☐**stiffness** ☐**swelling** ☐**deformity**

☐**numbness/ tingling** ☐**decreased motion** ☐**decreased strength**

Activities affected: ☐**ADLs** ☐**driving** ☐**writing** ☐**computer** ☐**sports** _____

Treatments for this problem: ☐**none** ☐**braces/splints** ☐**physical therapy** ☐**massage**

☐**cortisone injection** ☐**acupuncture** ☐**medication**_____

☐**surgery** (type/date) _____

Studies done: ☐**none** ☐**xray** ☐**MRI** ☐**EMG/Nerve Study** ☐**laboratory studies**

Have your symptoms improved since your last visit? (follow-up patients only) ☐**yes** ☐**no**

What are your goals for today's visit? _____