Name:

DOB:

Date:

OrthoCincy

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:

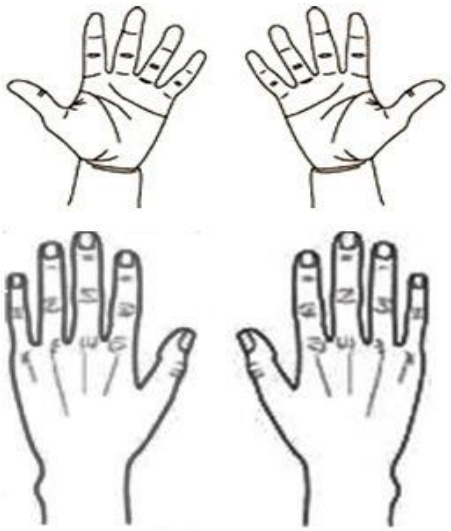
☐ Home ☐ School
☐ Work ☐ Sports field/court
☐ Other: _____

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: _____

Provider Signature: _____ Date: _____