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Hand Intake Sheet

NAME: _____

AGE : _____

REFERRED BY: _____

DOMINANT HAND: Right / Left / Both

AFFECTED HAND(S): Right / Left / Both

OCCUPATION: _____

DO YOU USE A KEYBOARD DAILY? Yes / No

HOBBIES: _____

MEDICAL PROBLEMS: _____

MEDICATIONS: _____

ALLERGIES (Including medications): _____

ARE YOU ALLERGIC TO SHELLFISH / IODINE? Yes / No

SMOKER? Yes / No If yes, how much? _____

PREGNANT? Yes / No

IS THE CURRENT PROBLEM THE RESULT OF AN INJURY? Yes / No

IF YES, HOW DID THE INJURY OCCUR? _____

WAS THE INJURY WORK-RELATED? Yes / No

IF YES, DESCRIBE THE USE OF YOUR HANDS AT WORK:

IF YES, HOW MANY HOURS PER DAY IN THIS ACTIVITY:

WAS THE INJURY THE RESULT OF A CAR ACCIDENT? Yes / No

IF YES, WERE YOU THE DRIVER? Yes / No

IF NO, WHERE WERE YOU SITTING? _____

IF YES, WAS THE CAR EQUIPED WITH AIR BAGS? Yes / No

IF YES, DID THE BAG(S) INFLATE? Yes / No

IF YES, WERE YOUR WEARING A SEAT BELT? Yes / No

DESCRIBE THE POSITION OF YOUR HANDS AT IMPACT:

DESCRIBE MAJOR COMPLAINTS ABOUT HAND(S):

DESCRIBE ANY PREVIOUS TREATMENT:

PREVIOUS HAND SURGERY? Yes / No

IF YES, Date: _____ Procedure: _____ Surgeon: _____
 Date: _____ Procedure: _____ Surgeon: _____
 Date: _____ Procedure: _____ Surgeon: _____

SYMPTOMS

(Please check where appropriate)

		Numbness	Tingling	Pain	How long?
RIGHT	Thumb	_____	_____	_____	_____
	Index finger	_____	_____	_____	_____
	Middle finger	_____	_____	_____	_____
	Ring finger	_____	_____	_____	_____
	Little finger	_____	_____	_____	_____
	Palm	_____	_____	_____	_____
LEFT	Thumb	_____	_____	_____	_____
	Index finger	_____	_____	_____	_____
	Middle finger	_____	_____	_____	_____
	Ring finger	_____	_____	_____	_____
	Little finger	_____	_____	_____	_____
	Palm	_____	_____	_____	_____

DO YOU HAVE PAIN? Yes / No

IF YES, IS IT Constant / Intermittent

Dull ache / Burning

Mild / Moderate / Severe

Aggravated by: Work ___ Squeezing ___ Pinching ___ Gripping ___

DO YOU HAVE SWELLING? Yes / No

IF YES, IS IT Constant / Intermittent

Aggravated by: Work ___ Dependent (down) position ___

Other _____

DO YOU HAVE NUMBNESS? Yes / No

IF YES, IS IT Constant / Intermittent

Associated with pain? Yes / No

Pins & needles ___ Lack of sensation ___ Excess sensitivity ___

Aggravated by: Work ___ Squeezing ___ Pinching ___ Gripping ___

Does it wake you up at night? Yes / No

Do you drop objects spontaneously? Yes / No

Have you had previous nerve (EMG) studies? Yes / No

If yes: Date: _____ Physician: _____

DO YOU HAVE CLICKING / SNAPPING? Yes / No

IF YES, IS IT Constant / Intermittent

Associated with pain? Yes / No

Location: _____

Aggravated by: Lifting ___ Opening jars/doors ___

Worse in the morning? Yes / No

PREVIOUS TREATMENT:

Tried	Relief	
_____	_____	Rest
_____	_____	Splints
_____	_____	NSAID's (i.e. Motrin, Advil)
_____	_____	Vitamin B6
_____	_____	Steroid injection
_____	_____	Physical Therapy

PREVIOUS DIAGNOSTIC STUDIES:

Plain X-rays _____ CAT Scan _____ MRI _____ Bone scan _____

Physician use only:

PHYSICAL EXAM (Carpal tunnel syndrome)

	Right		Left	
Thenar Atrophy	Y	N	Y	N
Tinel's	Y	N	Y	N
Phalen's	Y	N	Y	N
Oppose thumb & little finger	Y	N	Y	N

2 point discrimination (mm)

	Right	Left
Thumb	_____	_____
Index	_____	_____
Middle	_____	_____
Ring	_____	_____
Little	_____	_____