MILLER ORTHOPEDIC SPECIALISTS

HAND EVALUATION FORM

Name _____ Date_____

1. Which hand(s)/wrist(s) are we seeing you for? ☐ R ☐ L ☐ Both
2. Did you injure the hand/wrist? ☐ Yes ☐ No ☐ Gradual onset of symptoms
3. Date of injury or approximate date of gradual onset of symptoms: _____
4. Have you had any previous treatment for this condition? ☐ Yes ☐ No

   If Yes, who treated you? _____

   Date of initial treatment: _____

   Type of treatment: medication? ☐ Yes ☐ No

   If Yes, name(s) of medication: _____

   _____

   Splinting? ☐ Yes ☐ No

   Therapy? ☐ Yes ☐ No

   Work Modification? ☐ Yes ☐ No

   Approximate duration of above treatment: _____

5. Have you experienced any of the following problems? (please answer Yes or No)

Pain	In the hand_____	wrist_____	arm_____	shoulder_____
Swelling	In the hand_____	wrist_____	arm_____	shoulder_____
Stiffness	In the hand_____	wrist_____	arm_____	shoulder_____
Numbness	In the hand_____	wrist_____	arm_____	shoulder_____
Tingling	In the hand_____	wrist_____	arm_____	shoulder_____

   Do you experience pain at night? ☐ Yes ☐ No

   Do you experience numbness at night? ☐ Yes ☐ No

6. Does the hand ever become discolored (blue or red)? ☐ Yes ☐ No