UNIVERSITY of CALIFORNIA • IRVINE
HEALTHCARE

CENTER FOR HAND & UPPER EXTREMITY SURGERY
HAND & WRIST NEW PATIENT FORM

HISTORY

Welcome and thank you for choosing the UC Irvine Center for Hand & Upper Extremity Surgery for your care. Please take the time to answer all questions that apply to your problems as completely as possible.

Visit Date (mm/dd/yy): ____/____/____ Name (Last, First): _____

Date of birth (mm/dd/yy): ____/____/____ Age:_____ Sex: ☐ Male ☐ Female

Who referred you to this office?

☐ Referring Doctor: _____ Address: _____ Phone: _____

☐ Primary Physician: _____ Address: _____ Phone: _____

☐ Self Referral

A. Symptoms & Pain Assessment

1. Hand Dominance: ☐ Right ☐ Left ☐ Both

2. Upper Extremity affected: ☐ Right ☐ Left ☐ Both

   Which part of your arm is bothering you? (Please check ✓ in the box):

   ☐ Shoulder ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand
   ☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Small finger

3. Chief Complaint: _____

4. How long have you had these symptoms? _____ Days _____ Weeks _____ Months _____ Years

5. Describe your symptoms (Please check ✓ in the box):

   ☐ Pain ☐ Weakness ☐ Deformity ☐ Instability ☐ Abnormal motion ☐ Abnormal sensation
   ☐ Mass ☐ Swelling ☐ Laceration ☐ Other _____

6. How often do you experience these symptoms?

   ☐ Constant ☐ Intermittent ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

7. How did your symptoms start? ☐ Gradually ☐ Suddenly

   What date did your symptoms start?_____

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8. Was there any injury/event that caused your symptoms?

☐ No ☐ Yes - Date of Injury (mm/dd/yy): _____/_____/_____

Please describe how you were injured: _____

_____

a. Legal actions pending? ☐ No ☐ Yes

b. Work related?

☐ No

☐ Yes - Employer at time of injury: _____

Job Title: _____

Worker's Compensation? ☐ No ☐ Yes - Name of your attorney: _____

9. Any prior hand or upper extremity injury/pain before the event above?

☐ No ☐ Yes - What type? (Please describe) _____

10. Since your symptoms started, have they been getting: ☐ Better ☐ Worse ☐ Staying the same

11. What makes your symptoms better? (Please describe)

_____

_____

12. What makes your symptoms worse? (Please describe)

_____

_____

B. Previous Treatment & Evaluation

1. What diagnostic tests have you had for this problem?

☐ X-ray ☐ MRI ☐ CT ☐ EMG/NCS ☐ Blood tests ☐ Other _____

2. Please check ✓ if you have received any of the following:

☐ Surgery ☐ Steroid injections ☐ Physical therapy ☐ Massage ☐ Splinting

☐ Anti-inflammatory medications ☐ Other _____

Which treatment has been the **best** treatment?

_____

C. Medical/Surgical History

1. Please list other medical problems (Please check ✓ in the box):

☐ High blood pressure	☐ Arthritis	☐ Diabetes	☐ Heart disease - type: _____
☐ Stroke	☐ Osteoporosis	☐ High Cholesterol	☐ Cancer - type: _____
☐ Thyroid	☐ Asthma	☐ Stomach Ulcer	☐ Kidney stones
☐ Blood clots in leg	☐ Blood clots in lungs	☐ Depression	☐ AIDS/HIV

☐ Other _____

2. Have you ever had **hand or upper extremity surgery** in the past?

☐ No

☐ Yes - Type of hand or upper extremity surgery:

_____ Date: _____

_____ Date: _____

_____ Date: _____

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3. Please list other surgeries:

_____ Date: _____
_____ Date: _____
_____ Date: _____

D. Family Medical History (Please check ✓ in the box):

☐ Arthritis ☐ Bone Disease ☐ Heart Disease ☐ Diabetes ☐ Cancer

Mother	Age: _____	☐ Healthy	☐ Deceased due to: _____
Father	Age: _____	☐ Healthy	☐ Deceased due to: _____
Brother/Sister	Age: _____	☐ Healthy	☐ Deceased due to: _____
	Age: _____	☐ Healthy	☐ Deceased due to: _____

E. Social History (Please check ✓ in the box):

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you drink alcohol? ☐ No ☐ Yes If Yes, how much? _____

Do you smoke? ☐ No ☐ Yes If Yes, how much? _____

Do you use recreational substances? ☐ No ☐ Yes If Yes, Type and Frequency: _____

Are you currently working?

☐ No

☐ Yes - Employer: _____ Job Title: _____

Length of time on job: _____ hours/day _____ days/week

Movements required for your job (Please check ✓ in the box):

☐ pushing ☐ pulling ☐ grasping ☐ lifting _____ pounds

☐ reaching above shoulders ☐ repetitive wrist/hand movements

Machines used: _____

Are you able to perform your usual duties? ☐ No ☐ Yes

F. Review of Systems

(Please check ✓ in the box if you **currently** have any problems related to the following systems):

Skin
- ☐ Skin rash
- ☐ Easy bruising/bleeding
- ☐ Abnormal hair loss

Neurological
- ☐ Headache
- ☐ Migraine
- ☐ Seizure
- ☐ Paralysis

Eyes
- ☐ Visual loss
- ☐ Double vision
- ☐ Glaucoma
- ☐ Glasses/Contacts

Bone/Joint/Muscles
- ☐ Muscle wasting
- ☐ Muscle cramping
- ☐ Joint pain

Ears/Nose
- ☐ Deafness
- ☐ Hoarseness
- ☐ Vertigo/dizziness
- ☐ Sinusitis

Genitourinary
- ☐ Blood in urine
- ☐ Impotence
- ☐ Painful urination
- ☐ Kidney stones
- ☐ Incontinence

Mental Status
- ☐ Hallucination
- ☐ Nervous breakdown
- ☐ Depression
- ☐ Sleep disturbance
- ☐ Suicidal thoughts

Respiratory
- ☐ Shortness of breath
- ☐ Asthma/Bronchitis
- ☐ Cough
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Emphysema / COPD

F. Review of Systems (Continued)
(Please check ✓ in the box if you **currently** have any problems related to the following systems):

Gastrointestinal
- ☐ Appetite changes
- ☐ Jaundice
- ☐ Irritable bowels
- ☐ Nausea/Vomiting

Endocrine
- ☐ Goiter
- ☐ Heat/Cold intolerance
- ☐ Increased thirst

Cardiovascular
- ☐ Palpitations
- ☐ Chest pains
- ☐ Leg swelling
- ☐ Arrhythmia

Constitutional
- ☐ Fever/chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue

Blood System
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Bruising

MEDICATION

1. **Do you have any Allergies to Medications, Food or Latex?**
   - ☐ No
   - ☐ Yes - Allergies:_____ Reaction: _____
     Allergies:_____ Reaction: _____
     Allergies:_____ Reaction: _____

2. **Current Medications:**
   - ☐ None
   - ☐ Yes, listed below:

Medications	Dose	Route	Frequency	Time & Date Last Taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Patient's Signature: _____ **Date:** _____ **Time:** _____

MD Signature: _____ **Date:** _____ **Time:** _____

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.