Gavin Orthopaedics, LLC | The Sport&Spine Institute

Established Patient Hand/Wrist Visit

Date:_____

Age:_____

Patient Name: _____

Date of Birth _____

Referring Physician: _____ Primary Physician _____

Problem with: ☐ Right Hand/Wrist ☐ Left Hand/Wrist Estimated date first noticed problems: _____/_____/_____

Was this due to injury? ☐ Yes ☐ No Was injury work related? ☐ Yes ☐ No

Currently working? ☐ Yes ☐ No How did injury occur :_____

Prior Hand/Wrist surgery? ☐ Yes ☐ No If yes, list date, procedure and doctor

_____

How would you rate your worst pain? ☐ 1 (No pain), ☐ 2, ☐ 3, ☐ 4, ☐ 5, ☐ 6, ☐ 7, ☐ 8, ☐ 9 and ☐ 10 (severe pain)

Problem is presently: ☐ Worsening ☐ Unchanged ☐ Improving

The pain is? ☐ Constant ☐ Intermittent

Location? ☐ Finger _____ ☐ Wrist ☐ Dorsum (back)
☐ Volar (front) ☐ Radial (thumb side) ☐ Ulnar (5th finger side)

Please Circle: **Lt Hand?** **Rt Hand?**

Quality? ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Numbness
☐ Tingling ☐ Electric Shocks ☐ Locking

Timing? ☐ Night ☐ Morning ☐ At Work ☐ During Exercise ☐ After Exercise

Activities which were interfered with include:

☐ Sports ☐ Shopping ☐ Waking or Sleeping ☐ Gardening ☐ Working ☐ Other_____

Treatments that have been tried include:

☐ Anti Inflammatory_____	☐ Helped?	☐ Not Helped	☐ Physical Therapy	☐ Helped?	☐ Not Helped
☐ Pain Medications _____	☐ Helped?	☐ Not Helped	☐ Injection	☐ Helped?	☐ Not Helped
☐ Exercises	☐ Helped?	☐ Not Helped	☐ MRI		
☐ Reduced Activity	☐ Helped?	☐ Not Helped	☐ Other_____		
☐ Bracing	☐ Helped?	☐ Not Helped			

Review of Systems: Any Changes since the last visit with the following: Circle & Explain

☐ Weight Loss	☐ Mouth/Throat	☐ Kidneys/Bladder
☐ Fevers	☐ Heart	☐ Skin
☐ Eyes	☐ Lungs	☐ Nerves/Aniety/Depression
☐ Ears	☐ Stomach	☐ Bleeding/Clotting
☐ Nose	☐ Bowels	☐ Recurrent Infections

Explain: _____

New Medication?: _____

Recent Surgery?: _____

Any Questions for Dr. Gavin that you would like answered?: _____

_____

Patient Signature: _____

Physician Signature: _____