

CALIFORNIA ORTHOPAEDIC SPECIALISTS

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HAND & UPPER EXTREMITY INFORMATION FORM

Your name: _____ Age: _____

Whom may we thank for your referral? _____

Occupation: _____

Hobbies: _____

Hand dominance: Right: _____ Left: _____ Ambidextrous: _____

My present problem is with my: _____ Right _____ Left _____ Both

_____ Neck

_____ Shoulder

_____ Elbow

_____ Forearm

_____ Wrist

_____ Hand/Fingers

When did your hand or upper extremity problem begin? _____

Were you hurt on the job? _____

Does your injury involve a legal case? _____

Do you have diabetes? _____ If so, do you take insulin? _____

Please describe your current hand or upper extremity problem(s): _____

If you had an injury, please describe it in detail: _____

Is there a family history of hand or upper extremity problems? _____

Previous doctors you have seen for your hand or upper extremity problem:

Do you have any of the following? (Please check all which apply)

- Pain Tenderness Locking Grinding Discoloration
 Mass Clumsiness Swelling Drainage Instability
 Stiffness Deformity Popping Loss of strength
 Sensation of pins and needles Numbness/Decreased sensation

Does your pain wake you up at night? _____

What makes your pain worse? _____

What, if anything, relieves your pain? _____

Previous non-surgical treatments you have had for your hand or upper extremity problem (splints, casts, medications, physical therapy, etc.): _____

How many cortisone, steroid, or other types of injections have you had in your hand or upper extremity? _____

Previous hand or upper extremity surgeries (please list which upper extremity, procedure and date): _____

Have you had any infections, bleeding or any other complications from previous surgeries? _____
If so, please explain: _____

Are there any other aspects of your hand or upper extremity problems we should know about?

Do you have any other medical problems? _____
If so, please list them: _____

Signature: _____ Date: _____

Where on your body is the problem?

Describe the problem, please circle the applicable symptom:

Quality of pain – sharp, dull, throbbing, aching, shooting

Severity – minor, moderate, severe

Duration – intermittent, constant, lasting minutes, hours, days, etc.

Onset – when did the problem begin

Timing – with certain activities, at night only, etc.

Context – worsening, plateaued, improving

Modifying factors – rest, heat, ice, elevation, medications, therapies, etc., do they help?

Associated signs & symptoms – bruising, numbness, weakness, tingling, etc.

Have you ever had any of the following? If yes, please check and describe briefly.

Fevers Chills

Other bone joint muscle pains

Sinus Mouth Ear infections

Birth marks burns scars

Dentures

Loss of consciousness

Chest pain

Numbness weakness dizziness

Blood clots

Depression anxiety

Shortness of breath

Menopause taking hormones

Ulcers

Low blood count

Skin or eyes turn yellow

Easy bruising bleeding

Urinary incontinence infections

Problems with frequent infections

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Patient Name: _____ Date: _____

List all current and past medical problems, please circle where applicable and list treating

physicians:

Heart Circulatory Lungs Diabetes Kidney Liver Gastrointestinal
Deep Venous Thrombosis Rheumatoid Arthritis Osteoarthritis Neurological
Reproductive Thyroid Hypertension Other, please list:

List all surgeries, the years they were performed and in which hospital:

List all medications and dosages:

List allergies and describe your reaction (eg. penicillin – rash):

Family History and Relationship:

<input type="checkbox"/> Hereditary disorders	<input type="checkbox"/> Diabetes
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart disease	
Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D	Hobbies or Activities:

Occupation, present or former:

How much and what type of the following do you use per day?

Tobacco:

Alcohol:

Drugs:

Caffeine: