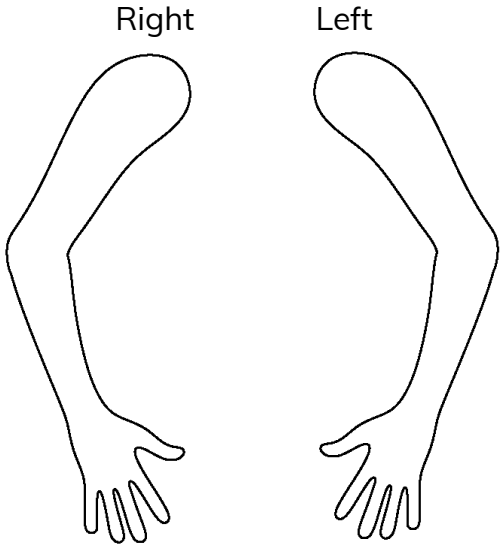
Hand & Elbow History & Physical

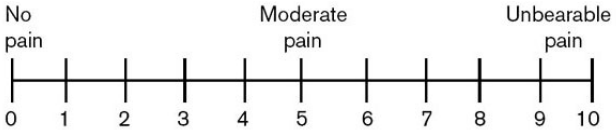
What hand do you write with? ☐ Left ☐ Right **What side is the problem?** ☐ Left ☐ Right ☐ Both	Patient Sticker
Height: **Weight:**	

Please mark location of pain or issue:
(X- numbness/tingling; 0- pain)



Name of your Primary Care / Referring Provider:

Circle a number from 0-10 that best describes how much pain you are having **RIGHT NOW.**



For a child or non-English speaking adult, use the FACES© pain rating scale below:

Please list any **ALLERGIES** you have to <u>medications or food/substances:</u>	☐ None
Please list all **prescription medications** and the dose that you take (or provide a list):	☐ None
Please indicate your **preferred** pharmacy with name/city/zip:	

When did you start to have pain? (date/time frame)

Was there a specific injury (if so, what happened)?

How do you describe the pain?

☐ Dull ☐ Aching ☐ Sharp ☐ Burning ☐ Numbing ☐ Tingling

What makes the pain better?	**What makes the pain worse?**

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What treatments have you tried: ☐ None

☐ NSAIDS (*Motrin, Ibuprofen*) or other medication
☐ Injections
☐ Splinting/immobilization
☐ Hand//Occupational/Physical Therapy
☐ Surgery
☐ Acupuncture
☐ Ergonomic Eval/adjustment
☐ Other_____

Please list any previous hand/elbow surgeries:	**Please list recreational Activities/sports:**
Occupation:	**Ethnicity:**

Have you used opioids for this or other injuries? ☐ Yes or ☐ No

Do you smoke/vape? ☐ Yes ☐ No Packs per day: _____ Years of use: _____ Quit Date: _____	**Do you use Smokeless Tobacco?** ☐ Yes ☐ No Quit Date: _____	**Alcohol Use:** ☐ Yes ☐ No Drinks/Week: _____

History of illegal drug use: ☐ Yes ☐ No Last use date: _____ If yes, what type? _____

Check and explain if you have any of the following:

☐ NONE OF THE BELOW

☐ Headache, dizziness, visual problems _____
☐ Ear, nose or throat problem _____
☐ Chest pain, irregular heartbeat, palpitations _____
☐ Lung problems, asthma, shortness of breath _____
☐ Difficulty or frequent urination _____
☐ Nausea, vomiting, diarrhea, heartburn _____
☐ Loss of sensation in your arms or legs _____
☐ Vascular disease _____
☐ Diabetes, thyroid or other endocrine problems _____
☐ Easy bruising _____
☐ Fevers, chills, night sweats _____
☐ Recent weight loss or gain _____

Today's Visit at MarinHealth Orthopedic Care:

To ensure you get the most out of your appointment, please list below the main concerns you'd like addressed. (As an example: review imaging studies, discuss medication management, explore non-operative treatments, etc.)

_____

_____

_____