Bellevue Bone and Joint Physicians
Hand Institute – New Patient Form

Thomas Trumble, MD

New Patient Hand and Upper Extremity Evaluation Form:

Patient to complete information below:

Name ______________________________ Date of Birth _______ Age _____ Right__ Left__ Handed?

How did you hear about us? □ Internet □ Patient Mailing □ Other ____

Referring Physician ____
Address ____ Phone ____________________

Primary Care Physician____
Address ____ Phone__________________

Work status?
Employed Unemployed Disabled Student Retired Homemaker

List your occupation and place of employment or school and grade if student or past occupation if retired:

____

Is this a work related problem? Yes___ No___ If yes, list your OWCP or L&I #_________________________
If disabled, when did you last work? ____
If you had an injury, how did it happen?

____

____

Please describe the problem that brings you into the office today: ____

____

Where is the problem located? **Right Left Both** (Please be specific.)
When did this problem begin (date of injury): _______________
Is there an attorney involved with your case? Yes No

- Circle the symptom or symptoms that best describe your problem:

  Stiffness Pain Instability Numbness Swelling Other ___________________________________

- If you have pain, please circle the description that is most appropriate:
  Sharp Throbbing Aching Burning Stabbing Heavy Dull
- Circle the number corresponding to the intensity of your pain:
  (0 = no pain / 10 = the worst pain imaginable) 0 1 2 3 4 5 6 7 8 9 10

- Circle all that apply:
  Are your symptoms getting: Better Gradually Better Rapidly Worse Gradually Worse Rapidly

- What improves your symptoms? (Circle all that apply.) Rest Ice Heat NSAIDs Other _______________

- What makes your symptoms worse? (Circle all that apply.) Activity Cold Pressure Other _____________________

- Have you had any previous surgery for this problem? **Yes No**

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If Yes, please describe: (please include where, when, the surgeon, and did they help)

____

____

- What studies have you had for this problem? (circle all that apply)

  X-rays CT MRI Nerve study (EMG) Arthrogram Bone Scan

- Past Medical History: **Do you have, or are you being treated for, any of the following:**

☐ Allergies (allergic rhinitis)	☐ Heartburn/reflux (GERD)
☐ Anxiety	☐ Heart attack (MI)
☐ Asthma	☐ Hepatitis ___ (please specify type)
☐ Bipolar	☐ High blood pressure (HTN)
☐ Bleeding/clotting disorder	☐ High cholesterol
☐ Cancer (CA)	☐ Neck Fusion
☐ Chronic lung disease/emphysema (COPD)	☐ Psoriasis
☐ Congestive heart failure (CHF)	☐ Rheumatoid Arthritis (RA)
☐ Coronary artery disease (CAD)	☐ Stroke/transient ischemic attack (TIA)
☐ Depression	☐ Thyroid disorder
☐ Diabetes	☐ Sleep disorder/trouble sleeping/(insomnia)
☐ Fibromyalgia	☐ Other (specify)________________________
	______________________________________

Allergies: (circle all that apply)

No known Drug Allergies	Erythromycin	Other: ________________________
Iodine	Penicillin (PCN)	
Sulfa	Latex	

Surgeries: (please circle all that applies)	Years	Other surgeries (excluding surgeries listed above): Procedure	Year
☐ No previous surgeries			
☐ Appendix (appendectomy)	_____	___________________________	_____
☐ Gall bladder (cholescystectomy)	_____	___________________________	_____
☐ By-pass/open heart (CABG)	_____	___________________________	_____
☐ Hernia repair	_____	___________________________	_____
☐ Hysterectomy	_____	___________________________	_____
☐ Tonsils removed (tonsillectomy)	_____	___________________________	_____
☐ C-Section	_____		

Family History: Please circle if any of your **family members** have had the following:

Diabetes	High Blood Pressure	Stroke	Heart attack	Cancer
Depression	Arthritis	Rheumatoid	Gout	Clotting disorder
Kidney disorder	Other ______________________________			

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- **Social History for Adult Patients:**

Marital status?
Single   Married   Divorced   Separated   Widowed   Domestic Partner

Do you have any children?
Yes ___ No ___   If so, how many _____ children?

Do you smoke?
Yes ___ No ___   If yes, how much per day? _____ How many year have you been smoking? _____

Do you drink alcohol?
Yes ___ No ___   If yes, how much? _____ drinks per week.

Have you ever had a drug or alcohol problem
Yes ___ No ___

- **Social History for Patients who are Children:** ☐ School Grade____ ☐ Living with ☐ Mother ☐ Father ☐ Both
- **Sports** ☐ Yes ☐ No ☐ Type of activity: _______________________

- **Review of Systems: (Please circle.)**

	No	Yes	Comments
General (weight gain/loss, fatigue, insomnia, fever/chills)			
Eyes (glasses/contacts, cataracts, glaucoma)			
Ear/Nose/Throat (sinus trouble, hearing loss)			
Heart (chest pain, high blood pressure, coronary artery disease, irregular heartbeat)			
Lungs (shortness of breath, asthma, lung disease)			
Stomach (heartburn, nausea, diarrhea, hepatitis)			
Muscle / Bones (joint pain, muscle pain, arthritis, fractures, sprains)			
Urinary Tract (painful urinating, kidney stones, prostate)			
Skin (masses, blisters, dermatitis, eczema)			
Neurologic (seizures, numbness/tingling)			
Mental Health (anxiety, depression)			
Endocrine (frequent urination, excessive thirst, diabetes, hypothyroid)			
Hematological (bleeding/clotting problems, anemia, swollen lymph nodes)			
Allergic / Immunologic (HIV/AIDS, hay fever lupus)			

Current Medications: **Dose:**   **Times per day:**   **Reason you are taking**

1.______________________________
2.______________________________
3.______________________________
4.______________________________
5.______________________________
6.______________________________
7.______________________________

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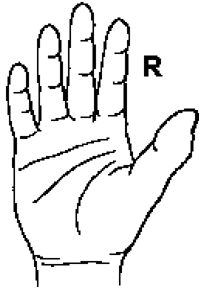
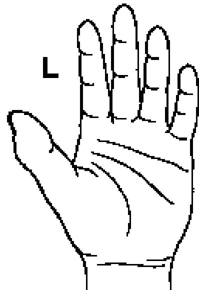
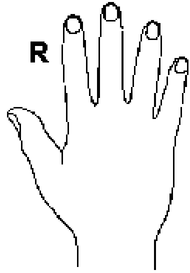
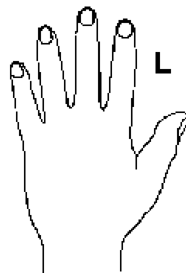
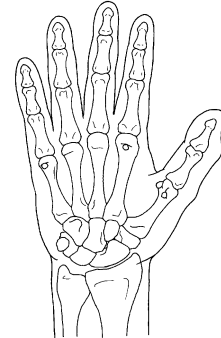
Physician to fill out this part: Physical Exam/Assessment/Plan











	• Right	• Left
Vascular		
Lymph		

Neurologic	• **Right** (NL < 5 mm)	• **Left (**NL < 5 mm)
Gross Sensation	NL or ABNL	NL or ABNL
2 Point Sensation		
Provocative Nerve Test	• **Right**	• **Left**
Tinel's		
Phalen's		
Cubital Tunnel Tinel's		
Other		

Wrist ROM	• **Right**	• **Left**
Flexion		
Extension		
Radial Deviation		
Ulna Deviation		
Strength		• NL or ABNL
Grip		
Pinch		

Finger ROM	**MCP**	**PIP**	**DIP**
H&P	**Normal**	**ABNL**	
HEENT	Clear		
Neck	w/o Mass		
Heart	Regular w/o M		
Lungs	Clear		
Abd	Benign		

Studies (EMG/NCV, X-Ray, MRI, CT):

____

Assessment Diagnosis:

____

Plan:

____

☐ Injection ☐ Lidocaine and Dexamethasone ☐ Lidocaine and Kenalog

☐ Discussed Risks and Benefits of Surgery____

☐ Ordered Therapy____

I was present for the _______________________ fracture management.

Signature of MD: ____