

Name: \_\_\_\_\_ MRN: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 Prov: \_\_\_\_\_ Date: \_\_\_\_\_



PHILADELPHIA  
 HAND TO SHOULDER  
 CENTER

**Philadelphia Hand to Shoulder Center  
 PATIENT DATA SHEET - Page 1**

*Note: It is the patient's responsibility to notify us  
 of any changes to the information provided.*

**E-Mail Address** (please print clearly): \_\_\_\_\_

**PHARMACY INFORMATION**

The Hand Center utilizes an electronic medical record; accordingly, whenever possible, we transmit prescriptions electronically.

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_  
 Pharmacy Address, City, St, Zip: \_\_\_\_\_

**FAMILY PHYSICIAN** \*We must have the FAX # so that we can fax a copy of your office visit report.

Physician Name: \_\_\_\_\_ Practice Name: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ \*Fax: \_\_\_\_\_

**PATIENT HISTORY**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Briefly, what problem are you being seen for today? \_\_\_\_\_

Date of Injury/Start of Symptoms? \_\_\_\_\_

Affected Side:  Right  Left  Both Dominant Hand:  Right  Left

Past Medical Problems (eg: Hypertension, Diabetes, Depression): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Previous Surgeries (include year performed, if known): \_\_\_\_\_  
 \_\_\_\_\_

Previous hand, wrist, arm, elbow, shoulder injuries and/or conditions: \_\_\_\_\_  
 \_\_\_\_\_

**CURRENT MEDICATIONS**

Name of Medication	Reason for Taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES TO MEDICATIONS**

Name of Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**OCCUPATIONAL/SOCIAL HISTORY**

Occupation: \_\_\_\_\_ How long have you been at your current job? \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Do you have children?  Yes  No If yes, how many? \_\_\_\_\_  
 Do you live with others?  Yes  No If yes, who lives with you? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No If yes, how many drinks per week? \_\_\_\_\_

**SMOKING STATUS**

Smoker # of cig. per day: \_\_\_\_\_ Year Started: \_\_\_\_\_  Former Smoker: Year Started \_\_\_\_\_ Year Quit \_\_\_\_\_  Never Smoked

**FAMILY HISTORY OF DISEASE/ILLNESS**

Relationship to you (check all that apply):

	Father	Mother	Sibling	Child
Diabetes Mellitus _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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### **PRIVACY PRACTICES ACKNOWLEDGEMENT & CONSENT**

Please complete top section of this form after reviewing our Notice of Privacy Practices.

#### **ACKNOWLEDGEMENT FORM**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Signature:  X

Date: \_\_\_\_\_

*If reviewed by Patient's Personal Representative:*

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### **GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE**

*For office use only when efforts to obtain acknowledgement of receipt of notice are unsuccessful*

Name of Patient: \_\_\_\_\_

#### **Personal representative information (if applicable):**

Name of personal representative: \_\_\_\_\_

Relationship to patient (or other authority): \_\_\_\_\_

I provided the above named person with the Notice of Privacy Practices for the Philadelphia Hand to Shoulder Center.

#### ***Describe how notice was provided:***

Offered copy and individual refused to accept delivery.

Offered copy and individual accepted delivery.

Other: \_\_\_\_\_

#### ***Describe efforts to obtain signature on acknowledgment of notice form:***

Patient/personal representative was asked to sign form and refused.

Other: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### **FOR OFFICE USE ONLY**

Employee Initials: \_\_\_\_\_

Office Location: \_\_\_\_\_

Name: \_\_\_\_\_ MRN: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 Prov: \_\_\_\_\_ Date: \_\_\_\_\_

# The QuickDASH Outcome Measure

## INSTRUCTIONS

- ☞ This questionnaire asks about your symptoms as well as your ability to perform certain activities.
- ☞ Please answer every question, based on your condition in the last week, by circling the appropriate numbers.
- ☞ If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
- ☞ It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

		NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1	Open a tight jar.	1	2	3	4	5
2	Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3	Carry a shopping bag or briefcase.	1	2	3	4	5
4	Wash your back.	1	2	3	4	5
5	Use a knife to cut food.	1	2	3	4	5
6	Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf hammering, tennis, etc.).	1	2	3	4	5

		NOT AT ALL	SLIGHTLY	MODERATELY	QUITE BIT <sup>A</sup>	EXTREMELY
7	During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

		NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8	During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. (circle number)		NONE	MILD	MODERATE	SEVERE	EXTREME
9	Arm, shoulder or hand pain.	1	2	3	4	5
10	Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

		NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11	During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number)	1	2	3	4	5

$$\text{QuickDASH DISABILITY/SYMPTOM SCORE} = \left( \left[ \frac{(\text{sum of } n \text{ responses})}{n} \right] - 1 \right) \times 25, \text{ where } n \text{ is equal to the number of completed responses.}$$

<sup>A</sup> QuickDASH score may not be calculated if there is greater than 1 missing item.