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	☐	☐	☐	☐
Gout	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

Name: _____ MRN: _____
DOB: _____ Age: _____
Prov: _____ Date: _____

Philadelphia Hand to Shoulder Center

PATIENT DATA SHEET - Page 2

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

REVIEW OF SYSTEMS

Are you currently having, or have you ever had, problems with:

	YES	NO
CONSTITUTIONAL		
Fever	☐	☐
Unexpected weight loss	☐	☐
Excessive fatigue	☐	☐
Night sweats	☐	☐
Loss of appetite	☐	☐
EYES		
Wear glasses or contacts	☐	☐
Infections	☐	☐
EARS, NOSE, THROAT		
Wear hearing aids	☐	☐
Hearing loss	☐	☐
Ear infections	☐	☐
Sinus problems	☐	☐
CARDIOVASCULAR		
Chest pain or angina	☐	☐
High blood pressure	☐	☐
Irregular pulse	☐	☐
Heart murmur	☐	☐
Heart attack	☐	☐
Blood clots	☐	☐
Do you have a Pacemaker?	☐	☐
Do you have a Defribillator?	☐	☐
RESPIRATORY		
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Chronic cough	☐	☐
Shortness of breath	☐	☐
Pneumonia	☐	☐
Lung cancer	☐	☐
Tuberculosis	☐	☐
GASTROINTESTINAL		
Ulcers or gastritis	☐	☐
Colon Cancer	☐	☐
Hepatitis	☐	☐
GENITOURINARY		
Urinary tract infections	☐	☐
Kidney stones	☐	☐
Kidney disease	☐	☐
INTEGUMENTARY		
Skin cancer	☐	☐
Skin ulcers	☐	☐

	YES	NO
MUSCULOSKELETAL		
Broken Bones	☐	☐
Arm weakness/pain	☐	☐
Leg weakness/pain	☐	☐
Joint pain or arthritis	☐	☐
Osteoporosis	☐	☐
Back pain	☐	☐
Scoliosis	☐	☐
NEUROLOGICAL		
Balance problems	☐	☐
Headaches	☐	☐
Fainting spells	☐	☐
Seizures	☐	☐
Stroke	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Thyroid disease	☐	☐
Hormone problems	☐	☐
HEMATOLOGIC/LYMPHATIC		
Anemia	☐	☐
Bleeding tendencies	☐	☐
Hemophilia	☐	☐
Blood transfusion	☐	☐
Lymphoma/leukemia	☐	☐
INFECTIOUS DISEASE		
HIV/AIDS	☐	☐
Other	☐	☐
ALLERGIC/IMMUNOLOGIC		
Nasal allergies	☐	☐
Immunologic disorders	☐	☐
PSYCHIATRIC		
Anxiety	☐	☐
Depression	☐	☐
Other psychiatric disorders	☐	☐

The information provided on this form is accurate to the best of my knowledge.

_____

Patient's Signature Date

I have reviewed the above information with the patient.

_____

Physician's Signature Date

Name: _____ MRN: _____
DOB: _____ Age: _____
Prov: _____ Date: _____

PHILADELPHIA
HAND TO SHOULDER
CENTER

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 A BIT	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

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

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