

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"/>

Name: _____
 DOB: _____
 Prov: _____

MRN: _____
 Age: _____
 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		YES	NO
CONSTITUTIONAL			MUSCULOSKELETAL		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Unexpected weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Arm weakness/pain	<input type="checkbox"/>	<input type="checkbox"/>
Excessive fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Leg weakness/pain	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain or arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
			Back pain	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL		
Infections	<input type="checkbox"/>	<input type="checkbox"/>	Balance problems	<input type="checkbox"/>	<input type="checkbox"/>
EARS, NOSE, THROAT			Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Wear hearing aids	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE		
CARDIOVASCULAR			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain or angina	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hormone problems	<input type="checkbox"/>	<input type="checkbox"/>
Irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGIC/LYMPHATIC		
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma/leukemia	<input type="checkbox"/>	<input type="checkbox"/>
RESPIRATORY			INFECTIOUS DISEASE		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC		
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Nasal allergies	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Immunologic disorders	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC		
Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL			Other psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers or gastritis	<input type="checkbox"/>	<input type="checkbox"/>			
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			
GENITOURINARY					
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>			
INTEGUMENTARY					
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>			
Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>			

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 BIT ^A	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

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

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