BECKER ORTHOPEDICS

Advanced skills and experience for the results you deserve

PATIENT INFORMATION SHEET

Elbow/Forearm/Wrist/Hand/Finger/Thumb
Right or Left

Name: _____

Date:_____

Please give a brief description of your symptoms/problems. (When and how does it hurt)

_____

_____

When did this start?
(approximate date or number of days, weeks, months, years)

_____

How did this happen? Were you injured?

_____

_____

Where is your problem? (Circle one or more)
Elbow/Forearm/Wrist/Hand
Finger 2 (index), 3(middle), 4(ring), 5 (little), Thumb + 1st digit (see diagram)

Is there? (circle words that apply and describe)
Pain/swelling/discoloring/open wound/weakness/tingling/numbness

Draw in area of problem on diagram.
Back of hand or front (palm) side (circle which side picture/diagram represents).

Have you had any surgery in this area?

If so, when? _____

If you know – describe surgery _____

Have you had any of the following exams done previously in this area?

X-ray	Where?_____	When?_____
Arthrogram	Where?_____	When?_____
Computed Tomography (CT)	Where?_____	When?_____
Magnetic Resonance Imaging (MRI)	Where?_____	When?_____