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Orthopedic Surgeon
Hand & Upper Extremity

Hand & Upper Extremity Questionnaire

Name: _____

Date of Birth: ___/___/___

Age: _____

Sex: _____

Handedness: _____

Occupation: _____

Who referred you here today? (check all that apply)

Self My Doctor (please list): _____

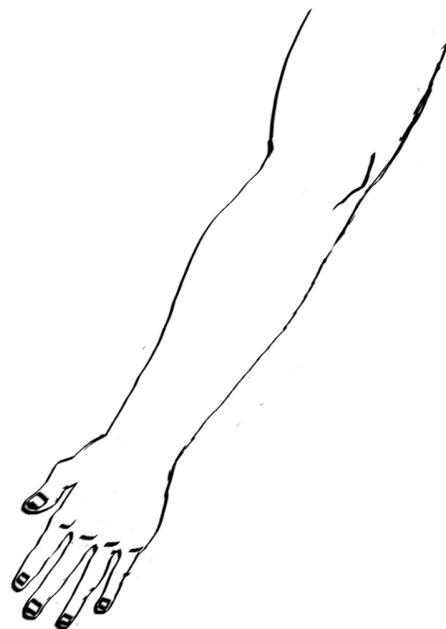
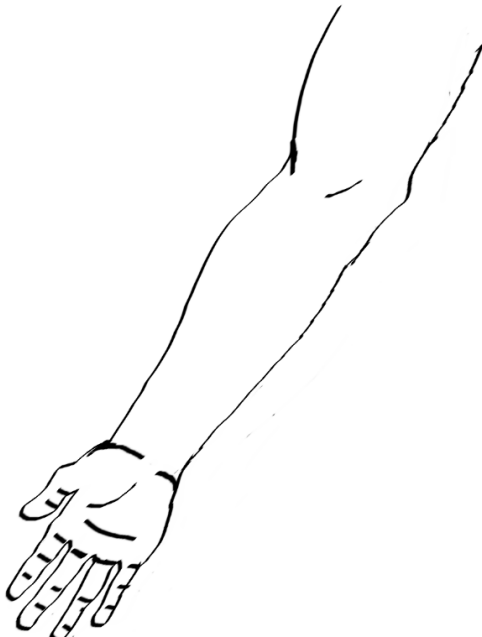
Other (please list): _____

What brings you in today? _____

Where is the issue? (check all that apply and mark on diagram(s) below)

Right

Left



What are your symptoms? (check all that apply)

Numbness/Tingling Pain/Throbbing Swelling Stiffness Weakness

Other (please describe): _____

When did it start? _____

What makes it better? _____

What makes it worse? _____

Was there an injury, and if so, how did it occur? _____

What have you tried for the symptoms? (check all that apply)

Over the counter medication (ibuprofen, Tylenol, etc.) Braces/Splints/Casts

Physical/Occupational Therapy Rest/Ice/Heat

Other (please describe): _____

What tests have you had done? (check all that apply)

X-rays MRI CT scan EMG/Nerve studies Labs

Other (please describe): _____