The Center *for* Plastic Surgery

- **Ramon De Jesus, MD**
- **Eva Dentcheva, MD**
- **Claude Hawkins, MD**
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- **Richard Tyrell, MD**

Name:		
DOB:		**Preferred Pronouns:** ☐ She / Her ☐ He / Him ☐ They /Their
Age:		
Email:		

Primary Care Physician	Physician Name:____ Practice Name:____ Phone:
Referring Physician	Physician Name:____ Practice Name:____ Phone:

Briefly, what problem are you being seen for today?

____

____

Date of Injury (if applicable):

Start of Symptoms:

Which hand do you write with: ☐ **RIGHT** ☐ **LEFT**	**Which side is affected:** ☐ **RIGHT** ☐ **LEFT**

What is your current work status:____

How long have you been at your current job:_______________________________________

How much do you have to lift at your job on a daily basis:______________________________

Have you had any previous injuries or procedures to your upper extremities:

____

Please list all of your allergies and reactions:

____

____

____

Past Medical History **→Please list your medical problems**	☐ Hypertension ☐ Diabetes ☐ Heart disease ☐ Kidney disease ☐ Lung disease ☐ ____ ☐ ____ ☐ ____ ☐ ____
Past Surgical History **→Please list all surgical procedures you have had**	____ ____ ____ ____ ____ ____
Social History	**Do you smoke?** ☐ YES o If yes, how many cigarettes daily? o If yes, what year did you start? ☐ Former smoker o What year did you start? o What year did you quit? ☐ Never Smoked **Do you drink?** ☐ YES o If yes, how many glasses per day? ☐ NO
Family History **→Please specify in whom**	☐ Diabetes ______________________________________ ☐ Gout ____ ☐ Rheumatoid Arthritis____________________________ ☐ Breast Cancer _________________________________ ☐ Other Cancer __________________________________ ☐ Bleeding disorders______________________________ ☐ Other____
Medications	**Name of Medication:** **Reason for Taking it:** 1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____ 7. ____ 8. ____ 9. ____ 10. ____

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

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

BC02-2

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.