Centre de Chirurgie St. Martin

PATIENT HISTORY FORM - HAND DISORDERS

DATE: _____

REGISTRATION

Patient: Last Name _____First Name_____ Initials _____
Home Phone_____ Work Phone_____ Email_____
Street Address_____
City _____Province _____ Postal Code _____
Sex ☐ M ☐ F Age_____ Birth date_____☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
RAMQ #_____ Driver's License #_____
Insured Name_____ How and where did you learn about this clinic?_____
Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____☐ Full-time ☐ Part-time City _____ Province _____ Zip _____Years Employed_____
SPOUSE (PARENT)	Name_____ Birthdate _____RAMQ:_____ Last Name First Name Initials Employer Name_____ Years Employed_____ Address _____Phone_____ Occupation_____ City_____ Province _____ Zip_____☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured: _____ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured: _____ID #:_____
AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No** Your Initials:_____ Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and Provincial Laws	***Legal Assignment Of Benefits And Designation Of Authorized Representative*** I'm requesting medical services from Dr. Remi Nader and his associates. I understand the implications of this request. I acknowledge that I am financially responsible for all expenses that will result thereof. A verification may be made to ascertain whether the insurance policy covers my treatment (if applicable). I understand that this is not guaranteed. I acknowledge that I am personally responsible for covering the required expenses of this treatment. I give permission hereby to the offices associated with Dr. Remi Nader to be reimbursed by the insurance company for all medical and surgical services performed by Dr. Remi Nader and partners (if applicable). I authorize my personal insurance (if applicable) to pay directly Dr. Remi Nader and his associates for medical services provided to me or to my dependent. I agree to communicate the necessary information to make the refund from the insurance carrier for me or my dependent (if applicable). The patient is responsible for paying the doctor in advance, regardless of whether the insurance policy covers the costs of the care provided. If necessary, an extension request must be previously discussed and approved by the offices associated with Dr. Remi Nader. I understand and agree to be legally responsible for all expenses and all fees that are incurred with the care provided by Dr. Remi Nader and his associates regardless of any insurance payment or benefit applicable Therefore, I authorize Dr. Remi Nader and his associates to transmit any medical information necessary for claim processing as stated by law. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the offices associated with Dr. Remi Nader, to the full extent permissible under the laws, , any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the offices associated with Dr. Remi Nader to issue any medical information to proceed to the recovery of the insurance company, a third person responsible for the payment of a financial entity, a responsible for my treatment, a local, provincial or federal representative in accordance with the law, an audit of a referral or medical coverage. I have read and fully understand this agreement. **X** _____ _____ Signature of Insured / Guardian Date

PATIENT HISTORY FORM - HAND DISORDERS

Patient Name:_____ Date:_____ Birthdate:_____

Height: _____ Weight: _____

Reason for Office Visit (briefly explain):_____
_____
_____
_____
_____

☐ Injury/Date of Injury _____

☐ Illness/Date Illness Began_____

☐ Symptoms/Date symptoms began _____

☐ Second Opinion/IME _____

Pain is:

☐ in the neck ☐in the shoulder ☐in the arm/hand

☐in the back ☐in the hip ☐in the leg/foot

☐ other_____
_____
_____

How long has pain been present?_____
_____
_____

Pain occurs with the following frequency:

☐ occasionally ☐ on and off ☐ all the time

☐ throughout the day ☐at night ☐no difference

Each episode of pain usually lasts: _____

☐seconds ☐minutes ☐hours ☐days ☐weeks

Are you: Right Handed_____ Left Handed _____ Use both Equally_____

Pain feels like:

☐a dull aching ☐sharp ☐stabbing ☐burning ☐cramping

Pain location: ☐middle of low back

☐ to Left or Right (circle) ☐across buttock / back

Intensity of pain (scale of 1-10: 1 –2 –3 –4 –5 –6 –7 – 8 – 9 – 10)

☐no pain (0) ☐ mild pain (1-2) ☐moderate pain (3-4)

☐severe pain (5-6) ☐very severe pain (7-8)

☐worst possible pain (9-10)

Mark the body position and /or activities that make pain better or worse:

a.	Sitting	☐ better	☐ worse
b.	Standing	☐ better	☐ worse
c.	Walking	☐ better	☐ worse
d.	Laying Down	☐ better	☐ worse
e.	At night, pain is	☐ better	☐ worse
f.	Coughing, Sneezing	☐ better	☐ worse
g.	Straining only	☐ better	☐ worse
h.	Movement	☐ better	☐ worse
i.	During the day pain is	☐ better	☐ worse
j.	No activity	☐ better	☐ worse

Previous tests done: Where/ when ?

☐MRI_____

☐CT Scan_____

☐Bone Scan/ other_____

☐EMG/NCV_____
_____
_____

Treatment done so far:

☐ rest ☐pain pills ☐muscle relaxants ☐anti-inflammatory non-steroidals ☐ Gabapentin (neurontin) ☐ Pregabalin (Lyrica) ☐wrist brace ☐chiropractic

☐physical thereapy ☐nerve blocks

☐Other injections (trigger point) ☐decompression of nerve or other surgery :

_____

Previous treatments have been:

☐unsuccessful ☐partially successful ☐very successful

Is current condition:

related to an accident ? ☐ yes ☐no

Covered under Workmen's Compensation? ☐ yes ☐no

related to an injury on the job? ☐yes ☐no

Under litigation? ☐yes ☐no

If yes, Name of Attorney_____

Phone#_____

Date of injury or accident_____

Centre de Chirurgie St. Martin

PATIENT HISTORY FORM - HAND DISORDERS

Patient Name:_____ Date:_____ Birthdate:_____

MEDICATIONS:
List all medication you are now taking & what they are for:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES:
List all medications you are allergic to and the reaction you have:_____
_____
_____

PAST HOSPITALIZATION / SURGICAL HISTORY:
Check any previous SPINAL surgeries and indicate the date(s) when they occured:
☐ NONE ☐ Thoracic _____
☐ Lumbar _____
☐ Cervical _____
Check all OTHER surgeries: ☐ NONE ☐ appendectomy
☐ cardiac surgery ☐ tonsil / adenoidectomy
☐ wisdom teeth removal ☐ gall bladder surgery
☐ other orthopedic surgery ☐ thyroid surgery
☐ breast surgery ☐ hernia repair ☐ Cesarean section
☐ Other _____

PERSONAL MEDICAL HISTORY
Do you have a history of medical problems or surgery of the following (please explain)?

	NO	YES	
Eyes	☐	☐	_____
Ears	☐	☐	_____
Skin	☐	☐	_____
Heart	☐	☐	_____
Circulation/Blood flow	☐	☐	_____
Lungs/Asthma	☐	☐	_____
Stomach	☐	☐	_____
Bowels/Intestines	☐	☐	_____
Kidneys	☐	☐	_____
Uterus/Prostate	☐	☐	_____
Depression/Mental problems	☐	☐	_____
Arthritis/Joints	☐	☐	_____
Blood clots/other problems	☐	☐	_____
High blood pressure	☐	☐	_____
Diabetes	☐	☐	_____
Cancer	☐	☐	_____
Brain seizures/Epilepsy	☐	☐	_____
Headaches/Migraines	☐	☐	_____
Dizziness/Fainting	☐	☐	_____
Hepatitis	☐	☐	_____

Other personal medical problems:
_____
_____

REVIEW OF SYSTEMS:
check items that applies to you:
Musculoskeletal / Joints: ☐ Muscular disease ☐ Arthritis
Neurological: ☐ Headaches ☐ Seizures ☐ Strokes
Metabolic: ☐ Diabetes ☐ Thyroid problems
Bleeding Disorders: ☐ Anemia ☐ Clots
☐ Bleeding problems
Urinary: ☐ Blood in Urine ☐ Frequent Urination
☐ Trouble Starting Urination
☐ Trouble Stopping Urination ☐ Pain with Urination
☐ Prostate Disease ☐ Kidney Disease
Respiratory: ☐ Asthma ☐ Bronchitis ☐ COPD
☐ Emphysema ☐ Pneumonia ☐ Tuberculosis
Cardiovascular: ☐ Chest Pain ☐ Mitral Valve Prolapse
☐ Irregular Heartbeats ☐ High Blood Pressure
☐ Shortness of Breath
Reproductive: ☐ Infections ☐ Herpes
☐ Venereal Disease
Gastrointestinal: ☐ Stomach Ulcers
☐ Gallbladder Problems ☐ Pancreatitis
☐ Colitis ☐ Blood in Stool ☐ Hiatal Hernia
☐ Liver Disease ☐ Constipation ☐ Loss of Bowel Control
☐ Hepatitis ☐ Jaundice
Cancer: ☐ Lung ☐ Breast / Colon / Intestinal ☐ Stomach
☐ Prostate ☐ Skin ☐ Kidney ☐ Bone
☐ Other Malignancy _____
Immunological Diseases: ☐ HIV Infection / AIDS

Women only: ☐ Endometriosis
Are you on the Pill? ☐ NO ☐ YES
Are you pregnant now? ☐ NO ☐ YES : due date: _____
How long ago was your last complete physical?
_____ yrs _____months
Were there any abnormal findings? ☐ NO ☐ Yes,
describe: _____

LIFESTYLE
Do you smoke NOW? ☐ No ☐ Yes:
Packs per day: _____ for _____ years
Did you smoke in the Past? ☐ No ☐ Yes:
Packs per day: _____ for _____ years
Do you drink alcoholic beverages? ☐ No ☐ Yes:
Drinks per week: _____ for _____ years
Do you have a history of drug abuse? ☐ No ☐ Yes:
Please describe: _____
_____

SOCIAL HISTORY:
Patient's Marital Status: ☐ Married ☐ Living common-law
☐ Widowed ☐ Divorced ☐ Separated ☐ Single
Number of children: _____
Hobbies: _____
Spouse Occupation: _____

PATIENT HISTORY FORM - HAND DISORDERS

Patient Name:_____ Date:_____ Birthdate:_____

FAMILY HISTORY:
Please check any of the problems immediate family have had and indicate the family member:
□ Diabetes □ High Blood Pressure □ Heart Disease
□ Neck Pain □ Back pain □ Low Blood Pressure
□ Kidney disease □ Depression/mental problems
□ Alzheimer /Memory loss □ Vascular Disease
□ Stroke/brain tumor/aneurysm
□ Lung problems □ Parkinson's □ Multiple Sclerosis
□ Cancer:_____
OTHER_____

Is there any reason you cannot receive blood or blood product: ☐ no ☐ yes: _____

OCCUPATIONAL HISTORY:
Occupation: _____
Employer: _____
When did this employer hire you? _____
Presently Working? □ Yes □ No
How long off work? _____

Does your job require you to perform the following activities:
□ Lift _____ kg / lb
□ Sit □ Stand
□ Lift over head □ Reach over head
□ Use a computer
□ Bend
□ Drive a truck or a forklift

If you are married, does your spouse work?
□ YES □ NO
If no, how long has he/she been off work? _____

ADDITIONAL PATIENT INFORMATION:
(Provide additional explanation of any response on this form in the space below)

I certify by my signature that the medical information given on this form is correct and complete to the best of my knowledge.

X _____ _____ _____
Signature of Patient or Personal Representative Date Verified by Physician/Nurse/ Medical assistant

X_____ _____ _____
Signature of Patient or Personal Representative Date Name (& Description of Personal Representative Authority if applicable)

AUTHORIZATION FOR USE & DISCLOSURE OF INFORMATION/ CONSENT TO PUBLICATION/PHOTOGRAPHY

I authorize Dr. Remi Nader, M.D., and partners to take photographs or videos of myself/ my surgery or the below named patient or to use information contained in my medical record such as history and physical, progress notes, consultations, operative reports, laboratory and pathology reports, radiological images and reports, other hospital and clinic documents for the purpose of medical publication and studies. I understand that the information mentioned above, could be used under these conditions

I understand that I have the right to revoke this authorization at any time and that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply for information that has already been released. I understand that this authorization is voluntary and I can refuse to sign this authorization. I fully and completely release Dr. Remi Nader, M.D., and partners from any claims or liabilities arising from the use of this information. I also understand that the information gathered will be the property of Dr. Remi Nader, M.D., and partners. I understand that disclosure of this information carries with it the potential of unauthorized redisclosure and the information may not be protected by federal and provincial confidentiality rules.

X_____ _____
Signature of Patient or Personal Representative Date

PATIENT HISTORY FORM - HAND DISORDERS

Boston Carpal Tunnel Syndrome Questionnaire

Patient Name:_____ Date:_____
DOB: _____Age:_____ M/F:_____

Please read carefully: The following questions refer to your symptoms for a typical twenty-four hour period during the past two weeks.
Circle one answer for each question

SERVERITY & FUNCTIONAL SCALE: 1 = None or Never 2 = Mild 3 = Moderate 4 = Severe 5 = Very Severe

1. How severe is the hand or wrist pain that you have at night?	Normal	Slight	Medium	Severe	Very serious
2. How often did hand or wrist pain wake you up during a typical night in the past two weeks?	Normal	Once	2 to 3 times	4 to 5 times	More than 5 times
3. Do you typically have pain in your hand or wrist during the daytime?	No pain	Slight	Medium	Severe	Very serious
4. How often do you have hand or wrist pain during daytime?	Normal	1-2 times / day	3-5 times / day	More than 5 times	Continued
5. How long on average does an episode of pain last during the daytime?	Normal	＜10minutes	10~60 Continued	＞60minutes	Continued
6. Do you have numbness (loss of sensation) in your hand?	Normal	Slight	Medium	Severe	Very serious
7. Do you have weakness in your hand or wrist?	Normal	Slight	Medium	Severe	Very serious
8. Do you have tingling sensations in your hand?	Normal	Slight	Medium	Severe	Very serious
9. How severe is numbness (loss of sensation) or tingling at night?	Normal	Slight	Medium	Severe	Very serious
10. How often did hand numbness or tingling wake you up during a typical night during the past two weeks?	Normal	Once	2 to 3 times	4 to 5 times	More than 5 times
11. Do you have difficulty with the grasping and use of small objects such as keys or pens?	Without difficulty	Little difficulty	Moderately difficulty	Very difficulty	Very difficult

Functional status scale (8 items)

	No difficulty	Little difficulty	Moderate difficulty	Intense difficulty	Cannot perform the activity at all due to hands and wrists symptoms
Writing	1	2	3	4	5
Buttoning of clothes	1	2	3	4	5
Holding a book while reading	1	2	3	4	5
Gripping of a telephone handle	1	2	3	4	5
Opening of jars	1	2	3	4	5
Household chores	1	2	3	4	5
Carrying of grocery basket	1	2	3	4	5
Bathing and dressing	1	2	3	4	5

PATIENT HISTORY FORM - HAND DISORDERS

Carpal Tunnel Syndrome Scoring

Clinical questionnaire for the diagnosis of CTS*	
INSTRUCTIONS: Circle YES, NO or N/A	
Has pain in the wrist woken you at night?	YES 1 NO 0
Has tingling and numbness in your hand woken you during the night?	YES 1 NO 0
Has tingling and numbness in your hand been more pronounced first thing in the morning?	YES 1 NO 0
Do you have/perform any trick movements to make the tingling, numbness go from your hands?	YES 1 NO 0
Do you have tingling and numbness in your little finger at any time?	YES 0 NO 3
Has tingling and numbness presented when you were reading a newspaper, steering a car or knitting?	YES 1 NO 0
Do you have any neck pain?	YES -1 NO 0
Has the tingling and numbness in your hand been severe during pregnancy?	YES 1 NO -1 N/A 0
Has wearing a splint on your wrist helped the tingling and numbness?	YES 2 NO 0 N/A 0
TOTAL =	

- A score of 3 or more has been submitted to analysis in comparison with nerve conduction studies.
- A score of 5 or more is recommended for use of the test as a diagnostic screening tool to replace nerve conduction studies.

** Reproduced from Appendix A from J Hand Surg [Br] 29(1):95-6 Kamath and Stothard, 'Erratum to: A clinical questionnaire for the diagnosis of carpal tunnel syndrome'. © 2004 The British Society for Surgery of the Hand.*

PATIENT HISTORY FORM - HAND DISORDERS

DASH SCORE

DISABILITIES OF THE ARM, SHOULDER, AND HAND SCORE

Patient Name: _____ **Date:** _____

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

ACTIVITIES	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
1. Open a tight or new jar	1	2	3	4	5
2. Write	1	2	3	4	5
3. Turn a key	1	2	3	4	5
4. Prepare a meal	1	2	3	4	5
5. Push open a heavy door	1	2	3	4	5
6. Place an object on a shelf above your head	1	2	3	4	5
7. Do heavy household chores (e.g. wash walls or floors)	1	2	3	4	5
8. Garden or do yard work	1	2	3	4	5
9. Make a bed	1	2	3	4	5
10. Carry a shopping bag or briefcase	1	2	3	4	5
11. Carry a heavy object (over 10 lbs.)	1	2	3	4	5
12. Change a lightbulb overhead	1	2	3	4	5
13. Wash or blow dry your hair	1	2	3	4	5
14. Wash your back	1	2	3	4	5
15. Put on a pullover sweater	1	2	3	4	5
16. Use a knife to cut food	1	2	3	4	5
17. Recreational activities which require little effort (e.g. card playing, knitting)	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g. golf, hammering, tennis)	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g. playing Frisbee, badminton)	1	2	3	4	5
20. Manage transportation needs (getting from one place to another)	1	2	3	4	5
21. Sexual activities	1	2	3	4	5
TOTAL					

PATIENT HISTORY FORM - HAND DISORDERS

DISABILITIES OF THE ARM, SHOULDER, AND HAND

Questions	Not at all	Slightly	Moderately	Quite a bit	Extremely
22. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups? (circle number)	1	2	3	4	5

Questions	Not at all	Slightly	Moderately	Quite a bit	Extremely
23. During the past week, were you limited in your or other regular activities as a result of your arm, shoulder, or hand problem? (circle number)	1	2	3	4	5

	None	Mild	Moderate	Severe	Extreme
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. (Circle number)

Questions	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	So Much Difficulty I Can't sleep
29. 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

Questions	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. (circle number)	1	2	3	4	5
TOTAL					

DASH DISABILITY/SYMPTOM SCORE = ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)