Dr. Kupperman's Questionnaire

ALTA ORTHOPAEDICS

Name: _____ **Date:** _____

Area of Problem: ○ Right ○ Left ○ Both

○ Hand ○ Wrist ○ Forearm ○ Elbow ○ Shoulder
○ Thumb ○ Index ○ Middle ○ Ring ○ Small
○ Other _____

Type of Problem: ○ Pain ○ Swelling ○ Numbness ○ Tingling
○ Stiffness ○ Weakness ○ Deformity ○ Mass/Lump
○ Other _____

Please indicate your pain level: no pain 0 1 2 3 4 5 6 7 8 9 10 severe pain

When did the problem start? Date?_____

Was this problem the result of an injury? ○ Yes ○ No

What type of injury? ○ Sports ○ Vehicle Accident ○ Work ○ Fall
○ Other_____

How often are you affected? ○ All the time ○ Sometimes ○ At night
○ Only during certain activities _____

How did the problem start? _____
_____
_____

What makes it better? _____

What makes it worse? _____

Have you had tests? please bring them with the results to your appointment
○ X-Ray ○ CT scan ○ MRI ○ EMG ○ Nerve Test

What treatments have you tried?
○ None ○ Rest ○ Ice ○ Heat ○ Medicine ○ Injection
○ Physical Therapy ○ Cast ○ Brace ○ Other_____

Please list any surgeries (with dates) that you have had to your hand and arm
_____
_____