

## ELBOW, WRIST, HAND SCREENING QUESTIONNAIRE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Have you recently had a trauma, such as a fall unto your hand?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you recently had a surgery for your neck, shoulder or arm?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have numbness or tingling in your hands?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has a doctor ever told you that you have osteoporosis (brittle bones)?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you recently had a sore, cut, scrape, or puncture wound, such as a human or animal bite? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you recently had an infection?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you recently or do you now have a fever?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you noticed an inability to move your wrist or elbow normally?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do your easily hands or feet turn white or become painful when cold?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you noticed any newly formed or irregular moles on your body?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. When you have pain, does it respond to pain medication?                                      | <input type="checkbox"/> | <input type="checkbox"/> |