BROWARD HAND CENTER

HARRIS GELLMAN M.D.
PURNELL TRAVERSO M.D.

HISTORY OF INJURY

DATE COMPLETED _____ / _____ /_____
MM DD YYYY

NAME _____ _____ _____ AGE _____ SEX : M F
(First) (MI) (Last) Circle

ARE YOU?: ☐RIGHT-HANDED ☐LEFT-HANDED ☐AMBIDEXTROUS

JOB TITLE: _____ DATE OF INJURY ____ / ____ /_____
MM DD YYYY

EMPLOYER AT TIME OF INJURY: _____

JOB DESCRIPTION: _____

_____

WHAT HAPPENED? _____

_____

_____

DID YOU REPORT THE INJURY TO YOUR SUPERVISOR: ☐ YES ☐NO ☐N/A DATE REPORTED ____ / ___ /_____
MM DD YYYY

WHAT DOCTOR/CLINIC/HOSPITAL/ER DID YOU GO TO?_____ DATE SEEN ____ / ___ /_____
MM DD YYYY

XRAYS TAKEN? YES NO OTHER STUDY: _____

WHAT WERE YOU TOLD WAS WRONG?

_____

_____

WHAT TREATMENT DID YOU HAVE?

MEDICATIONS: _____

_____

SPLINTS/CAST/BANDAGES (HOW LONG?) _____

_____

SURGERY (DATE AND TYPE): _____

PHYSICAL THERAPY (LENGTH OF THERAPY): _____

ALLERGIES: _____

OTHER TREATMENTS (WITH DATES): _____

_____

CURRENTLY UNDER TREATMENT? ☐YES ☐NO IF YES… WHAT TYPE? _____

_____

LIST OF NAMES OF ALL DOCTORS WHOM YOU HAVE SEEN FOR THIS PROBLEM:

DATE	NAME	TREATMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

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WHAT SYMPTOMS ARE YOU PRESENTLY EXPERIENCING? _____

_____

ARE YOU HAVING PAIN: ☐YES ☐NO
(IF YES…) AT REST? ☐YES ☐NO
WITH ACTIVITY? ☐YES ☐NO (IF YES EXPLAIN): _____

_____

DOES IT INTERFERE WITH USE OF YOU HAND? ☐YES ☐NO (IF YES EXPLAIN?): _____

_____

HAVE YOU EVER HAD THESE OR OTHER SYMPTOMS WITH YOUR HAND OR ARM PREVIOUSLY? ☐YES ☐NO

(IF YES: STATE WHEN DID IT START AND EXPLAIN): _____

_____

HAVE YOU EVER HAD ANY OTHER INJURY TO YOUR UPPER EXTREMITY? ☐YES ☐NO

(IF YES EXPLAIN): _____

_____

HOW MANY HOURS PER WEEK DO YOU WORK: _____

DESCRIBE WHAT YOU DO AT WORK: _____

_____

DO YOU HAVE A SECOND JOB? ☐YES ☐NO (IF YES, HOW MANY HOURS PER WEEK?) _____

(WHAT DO YOU DO?) _____

_____

PLEASE LIST ALL ATHLETIC, EXERCISE, MUSICAL, AND MANUAL ACTIVITIES OUTSIDE OF WORK:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ARE YOU CURRENTLY WORKING? ☐YES ☐NO

IF YES… ☐FULL DUTY ☐MODIFIED DUTY (RESTRICTIONS?) _____

☐REDUCED HOURS? (IF YES HOW MANY HOURS PER WEEK?) _____

WHAT TIME HAVE YOU LOST FROM WORK AS A RESULT OF THIS INJURY?

TOTAL DISABILITY: (DATE) _____ TO _____

PARTIAL DISABILITY: (DATE) _____ TO _____

PLEASE LIST ALL PRIOR EMPLOYERS, JOB TITLE AND DATES, LISTING MOST RESENT FIRST:

DATE	EMPLOYER	JOB TITLE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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