Lancaster Plastic Surgery Associates

Carpal Tunnel Symptom Intake Form

Please complete this short form before your consultation. It allows us to focus our time on your specific symptoms and goals. Answer as completely as you can.

1. Patient Information

Full Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Preferred contact: ☐ Phone ☐ Text ☐ Email

2. Which Hand(s) Are Affected?

☐ Right hand only ☐ Left hand only ☐ Both hands

If both hands, which is worse? ☐ Right ☐ Left ☐ About the same

Dominant hand: ☐ Right ☐ Left ☐ Ambidextrous

3. Current Symptoms (check all that apply)

☐ Numbness or tingling in the fingers

☐ Pain in the hand, wrist, or forearm

☐ Nighttime symptoms that wake you from sleep

☐ Weakness or dropping objects

☐ Burning or aching sensation

☐ Clumsiness with fine tasks (buttons, keys, writing)

☐ Symptoms worse when driving, holding a phone, or typing

☐ Symptoms worse with gripping or repetitive hand use

Which fingers are most affected? (check all that apply)

☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Little ☐ Entire hand

4. Timeline & Severity

How long have you had these symptoms?

☐ Less than 3 months ☐ 3–6 months ☐ 6–12 months ☐ More than 1 year

Do your symptoms wake you at night? ☐ Yes ☐ No ☐ Sometimes

Average symptom severity (0 = none, 10 = worst imaginable): _____ / 10

Severity at its worst (night or after activity): _____ / 10

5. Daily Function & Work

Occupation / main daily activities: _____

Do symptoms interfere with work, hobbies, or sleep? ☐ Yes ☐ No ☐ Somewhat

If yes, briefly describe how: _____

6. What Have You Already Tried?

☐ Nighttime wrist splints or braces

☐ Activity modification or rest

☐ Over-the-counter anti-inflammatory medication

☐ Physical or occupational therapy

☐ Corticosteroid (cortisone) injection into the wrist

☐ Other treatment: _____

Have you had nerve testing (EMG / nerve conduction study)?

☐ Yes ☐ No ☐ Not sure If yes, approximately when? _____

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7. Relevant Medical History (check any that apply)

- ☐ Diabetes or prediabetes
  If yes, most recent A1C: _____ Date of that A1C: _____
- ☐ Thyroid disorder
- ☐ Rheumatoid or other inflammatory arthritis
- ☐ Current or recent pregnancy
- ☐ Previous wrist fracture, injury, or surgery
- ☐ Kidney disease
- ☐ Other relevant conditions: _____

Are you currently taking any blood thinners or antiplatelet medications?

(Examples: aspirin, warfarin/Coumadin, Eliquis, Xarelto, Plavix, Brilinta, Lovenox, etc.)

☐ Yes ☐ No

If yes, list the medication(s) and dose if known: _____

8. Anything Else We Should Know?

_____

_____

_____

Patient Signature & Date

Signature: _____ Date: _____

Thank you. Please bring the completed form to your consultation (or return it in advance if requested). This information helps us make the most of your visit.