Lancaster Plastic Surgery Associates
Ganglion Cyst 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. Where Is the Cyst Located?

☐ Right wrist ☐ Left wrist ☐ Right finger ☐ Left finger

If wrist: ☐ Dorsal (back of hand) ☐ Volar (palm side)

If finger, which one? ☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Little

Dominant hand: ☐ Right ☐ Left ☐ Ambidextrous

Approximate size of the lump: _____ cm (or describe: _____)

3. Current Symptoms (check all that apply)

☐ Visible or palpable lump / bump
☐ Pain or aching at the site of the cyst
☐ Pain that radiates into the hand, wrist, or finger
☐ Cyst changes in size (comes and goes or fluctuates)
☐ Weakness, numbness, or tingling near the cyst
☐ Interference with gripping, writing, or daily tasks
☐ Cosmetic concern (appearance of the lump)
☐ Symptoms worse with certain activities (describe below)

4. Timeline & Severity

How long have you had the cyst or symptoms?

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

Has the cyst been drained/aspirated before? ☐ Yes ☐ No ☐ Not sure

If yes, how many times and when was the most recent? _____

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

Severity at its worst: _____ / 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?

☐ Observation / watching and waiting
☐ Activity modification or rest
☐ Over-the-counter anti-inflammatory medication (ibuprofen, etc.)
☐ Splinting or bracing
☐ Aspiration (needle drainage) of the cyst
☐ Corticosteroid (cortisone) injection
☐ Other treatment: _____

How many aspirations or injections have you had for this cyst (if any)? _____

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
☐ Osteoarthritis (especially of the fingers or wrist)
☐ Current or recent pregnancy
☐ Previous hand, wrist, or finger 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.