**Lancaster Plastic Surgery Associates**

Trigger Finger 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) and Finger(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

Which fingers are affected? (check all that apply)

☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Little

## 3. Current Symptoms (check all that apply)

- ☐ Finger locks, catches, or clicks when bending or straightening
- ☐ Pain or tenderness at the base of the finger (palm side)
- ☐ Morning stiffness or locking that improves with use
- ☐ Swelling or a nodule (bump) at the base of the finger
- ☐ Difficulty fully straightening or bending the finger
- ☐ Symptoms worse with gripping, pinching, or repetitive use
- ☐ Finger stays locked and needs to be manually straightened

## 4. Timeline & Severity

How long have you had these symptoms?

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

Does the finger lock (get stuck)? ☐ Yes ☐ No ☐ Sometimes

If it locks, can you straighten it yourself? ☐ Yes ☐ No (needs help)

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

Severity at its worst (morning 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?

- ☐ Activity modification or rest
- ☐ Over-the-counter anti-inflammatory medication (ibuprofen, etc.)
- ☐ Splinting or buddy taping
- ☐ Physical or occupational therapy / home exercises
- ☐ Corticosteroid (cortisone) injection into the tendon sheath
- ☐ Other treatment: _____

How many cortisone injections have you had for this finger (if any)? _____

When was the most recent injection? _____

## 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 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.*