Filled in by staff

☐ **3 months** ☐ **12 months** ☐ **Other** (indicate no. of months) ☐☐

HAKIR
Hand Surgery Quality Record

Patient's Personal Identity No. (12 digits) ☐☐ ☐☐☐☐☐☐–☐☐☐☐

Form filled in on (yyyy-mm-dd) ☐☐☐☐-☐☐-☐☐

PATIENT QUESTIONNAIRE

First name (block letters):

Last name (block letters):

You are: ☐lefthanded ☐righthanded ☐ ambidextrous

Arm/hand that was operated on: ☐ Left ☐ Right

This questionnaire has to do with pain/problems you have had this past week in the hand/arm that was operated on. Please indicate the degree of pain by placing a single "X" on each line.
Please do not place an X beyond the line.

1. Pain when bearing weight

No pain ——— Worst possible pain

2. Pain when moved without bearing weight

No pain ——— Worst possible pain

3. Pain at rest

No pain ——— Worst possible pain

4. Stiffness

No problems ——— Worst possible problem

5. Weakness

No problems ——— Worst possible problem

6. Numbness / tingling in fingers

No problems ——— Worst possible problem

7. Cold sensitivity in fingers

No problems ——— Worst possible problem

8. Problems with hand function in daily activities

No problems ——— Worst possible problem

9. How satisfied are you with the results of the operation?

Totally satisfied ——— Totally dissatisfied

10. How satisfied are you with the care that you received by the clinic during your treatment?

Totally satisfied ——— Totally dissatisfied

Filled in by staff

☐ **3 months** ☐ **12 months** ☐ **Other** (indicate no. of months) ☐☐

Patient's Personal Identity No. (12 digits) ☐☐ ☐☐☐☐☐☐–☐☐☐☐

Form filled in on (yyyy-mm-dd) ☐☐☐☐-☐☐-☐☐

QuickDASH (arm/shoulder/hand)

This form has to do with your symptoms and your ability to perform certain activities. Answer **each question**, on the basis of how you have been feeling **this last week**, by marking one of the alternatives for each question. If there is some activity that you have not done this past week, then mark the answer that you think **would be most correct** had you done the activity. It does not matter which arm or hand you use to perform the activity. The answer is based upon your ability regardless of how you do it.

	No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	Unable
1. Open a tight or new jar.	☐	☐	☐	☐	☐
2. Do heavy household chores (e.g., wash walls, floors).	☐	☐	☐	☐	☐
3. Carry a shopping bag or briefcase.	☐	☐	☐	☐	☐
4. Wash your back.	☐	☐	☐	☐	☐
5. Use a knife to cut food.	☐	☐	☐	☐	☐
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	☐	☐	☐	☐	☐

7. During **the past week**, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

8. During **the past week**, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?

☐ Not limited at all ☐ Slightly limited ☐ Moderately limited ☐ Very limited ☐ Unable

Please rate the severity of the following symptoms **in the last week:**

	None	Mild	Moderate	Severe	Extreme
9. Arm, shoulder or hand pain.	☐	☐	☐	☐	☐
10. Tingling (pins and needles) in your arm, shoulder or hand.	☐	☐	☐	☐	☐

11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand?

No difficulty | Mild difficulty | Moderate difficulty | Severe difficulty | So much difficulty that I can't sleep