

Orthopaedic Specialists of Central Arizona

Patient Medical History – Upper Extremity

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Occupation: _____ Retired? Yes No

Primary Care Doctor: _____ Who referred you to our office? _____

What are you being seen for today? _____

Have you seen a doctor for this problem before? No Yes If yes, who? _____

When did your current problem begin to cause you symptoms? _____

Did a specific injury or accident start your symptoms? No Yes Is Injury Work-Related? No Yes

If Yes, when was the injury/accident and how did it occur? _____

Are you currently involved in an accident or disability litigation/legal action? No Yes

Were images taken? (Xray or MRI) No Yes If yes, where? _____

Are you: Right or Left Handed (Please circle)

On a scale of 0 – 10, (0 meaning no pain and 10 meaning the worst pain imaginable) how severe is your pain?

Most of the time: 0 1 2 3 4 5 6 7 8 9 10

When the pain is the worst: 0 1 2 3 4 5 6 7 8 9 10

When the pain is the least: 0 1 2 3 4 5 6 7 8 9 10

Has your pain recently: Worsened Not changed Improved Gone away

Describe the type of symptoms you experience (check all that apply):

- Sharp/stabbing Throbbing Shooting Aching Cramping Stiffness
 Burning Tingling Numbness

Describe when your pain occurs (check all that apply):

- Worse in the morning Worse during the middle of the day Worse at the end of the day
 Keeps or wakes me up at night Does not vary significantly during the day

Pain is made **worse** by (check all that apply):

- Sleeping on your side Lifting Reaching above your head Driving Exercise

Pain is made **better** by (check all that apply):

- Resting Lying down Heat Ice Exercise Nothing seems to make the pain better

Have you taken any medicines for your pain?

Tylenol NSAID's Narcotic pain pills Glucosamine/Chondroitin/MSM-type supplements

Do you have any pain below your elbow? Yes No

Do you have any neck pain? Yes No

Please describe any limitations in your activity caused by your pain or other symptoms:

I have pain if I lift over ____ lbs The pain limits my ability to exercise

Getting dressed is difficult Combing/brushing my hair is difficult

Do you use a cane, crutches, or a walker? No Yes If yes, please circle which one.

Please list all operations you have had (name and date):

How often do you exercise? Daily 1-2d/wk 3-4d/wk >5 d/wk

What types of exercise do you usually do? _____

Do you smoke or chew tobacco? (please circle) No Yes If yes, how much and for how long? _____

Have you used tobacco in the past? No Yes If yes, when did you quit? _____

How many alcoholic beverages do you have in a day? _____ A week? _____

Have you ever used or currently use illegal IV drugs? No Yes If yes, please explain: _____

Have you had or now have any infectious diseases such as Hepatitis, Tuberculosis, HIV/AIDS?

No Yes If so, please list: _____ HIV tested? No Yes

What diseases, if any, are common in your family? (i.e. diabetes, heart attacks, cancer, etc.)

Height: _____ Weight: _____

Patient Name: _____

Review of Systems

In the **past week** have you experienced any of the following problems? Please circle all that apply:

- | | | | |
|--------------------|---------------------|--|-------------------|
| Fever | Sore throat | Nausea/vomiting | Depression |
| Chills | Bloody sputum | Constipation/diarrhea | Poor sleep |
| Weight loss | Cough | Urination problems | Anxiety |
| Weight gain | Swollen glands | Kidney/bladder problems | Tremors |
| Night sweats | Chest pain | Sore joints | Seizures |
| Fatigue | Swollen feet | Muscle aches | Infections |
| Vision problems | Shortness of breath | Skin rash | Fainting |
| Hearing difficulty | Abdominal pain | New moles | Headaches |
| Nasal congestion | Ulcers | Dizziness | Bleeding problems |
| Other : _____ | | ○ I have had none of the above problems | |

Please indicate any and all medical conditions for which you have been treated:

	Under active treatment	Been treated in the Past
Heart disease	_____	_____
Heart attack	_____	_____
Congestive heart failure	_____	_____
Irregular heart beat	_____	_____
Hypertension (High blood pressure)	_____	_____
Diabetes	_____	_____
Blood clots in your legs	_____	_____
Blood clots in your lungs	_____	_____
Stroke	_____	_____
Osteoporosis (weak bones)	_____	_____
Bleeding problems	_____	_____
Anemia	_____	_____
COPD/Emphysema/Bronchitis (circle)	_____	_____
Sleep Apnea	_____	_____
Stomach/Intestinal Ulcer	_____	_____
Gastritis/Reflux disease (circle)	_____	_____
Leukemia/Lymphoma (circle)	_____	_____
Thyroid disease	_____	_____
Liver disease	_____	_____
Hepatitis	_____	_____
Cirrhosis	_____	_____
Kidney disease	_____	_____
Bladder infection	_____	_____
Prostate difficulty	_____	_____
Severe body aches	_____	_____
Fibromyalgia	_____	_____
MRSA infection	_____	_____
Dental infections or loose teeth	_____	_____
HIV/AIDS	_____	_____
Depression	_____	_____
Poor circulation	_____	_____
Rheumatoid Arthritis	_____	_____
Other _____	_____	_____

By signing below, I certify that I have understood the questions and have answered honestly and to the best of my knowledge.

Signature: _____ Date: _____

Printed Name: _____

*We, at OSCA, assure you that the above information is part of your personal and private medical record. As such, it will not be shared with anyone outside this office without your specific, written permission, except for circumstances wherein we are required to do so by law.

