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.

ORTHOPAEDIC SPECIALISTS OF CENTRAL ARIZONA – MEDICATION LIST

PATIENT NAME: ____________________________________ DATE OF BIRTH: ___________________

ALLERGIES: Drugs/ Foods	REACTIONS/Side Effects	ALLERGIES: Drugs/ Foods	REACTIONS/Side Effects

Please list all medications you currently take, including Prescriptions, Over-the-Counter, Patches, Inhalers, Vitamins, Herbal Supplements and Eye drops.

DRUG NAME	DOSE	ROUTE e.g. oral, injectable, inhaled	FREQUENCY	REASON

Patient Signature: ____________________________________ Date: ___________________

Reviewing Staff: ____
Reviewing Staff Signature: ______________________________ Date: ____________________