Orthopaedic Specialists of Central Arizona

Judah D Pifer, MD • Brad D Williams, MD

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

Have you taken any medicines for your pain?

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

Have you had any prescribed treatment for your pain?

☐ Physical Therapy ☐ Cortisone injections ☐ Lubricating injections (Synvisc, Supartz, Euflexxa)

☐ Other: _____

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 pain better

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 ☐

Height:_____ Weight:_____

Patient Name: _____Date of Birth: _____

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

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

_____ _____ _____ _____

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

Under current active or past treatment?	Current	Past	*Under current active or past treatment?*	Current	Past
Heart disease or heart attack (circle)			Gastritis/Reflux disease (circle)		
Pacemaker			Leukemia/Lymphoma (circle)		
Congestive heart failure			Thyroid disease		
Irregular heart beat			Liver disease or Cirrhosis (circle)		
Hypertension (High blood pressure)			Kidney disease		
Diabetes			Bladder infection		
Blood clots in your legs or lungs (circle)			Prostate difficulty		
Stroke			Severe body aches/ Fibromyalgia (circle)		
Osteoporosis (weak bones)			**Medical Implants:**		
Bleeding problems / Anemia (circle)			MRSA infection		
COPD/Emphysema/Bronchitis (circle)			Tuberculosis		
Sleep Apnea			HIV/AIDS		
Stomach/Intestinal Ulcer (circle)			Rheumatoid Arthritis		
Other:			Other:		

*Current Mailing Address: _____
*Current Phone Number: _____

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: _____ Date of Birth: _____

*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.

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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: _____