

# *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

Have you had any prescribed treatment for your shoulder pain?

Physical Therapy     Injections     Other: \_\_\_\_\_

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.

Current medications (incl. vitamins and supplements): name, dosage, frequency (e.g. Coumadin 1mg, 1x/day)

\_\_\_\_\_

Please list any medications that you are **allergic** to, and the reaction you experienced to the medication:

\_\_\_\_\_

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 to 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 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 : _____      |                     | ○ <b>I have had none of the above problems</b> |                   |

**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.