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 : _____		○ **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.