

# *Orthopaedic Specialists of Central Arizona*

## **Return Patient Medical History – Upper Extremity**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_

Retired? Yes  No  Occupation: \_\_\_\_\_

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? (Xrays 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 medications 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.

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):

Are you currently under the care of a Physician for any medical conditions? If yes, please explain.

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 MRSA infection, Hepatitis, Tuberculosis, HIV/AIDS?

No  Yes  If so, please list: \_\_\_\_\_

### **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 : _____      |                     |                         |                   |

o **I have had none of the above problems**

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.