Orthopaedic Specialists of Scottsdale

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? ☐ Yes ☐ No If yes, who? _____

When did your current problem begin to cause you symptoms? _____

Did a specific injury or accident start your symptoms? ☐ Yes ☐ No Is Injury Work-Related? ☐ Yes ☐ No
If Yes, when was the injury/accident and how did it occur? _____

Are you currently involved in an accident or disability litigation/legal action? ☐ Yes ☐ No

Were images taken? (X-ray or MRI) ☐ Yes ☐ No 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: _____
When the pain is the worst: _____
When the pain is the least: _____

Has your pain recently: ☐ Worsened ☐ Not changed ☐ Improved ☐ Gone away

Does your pain localize to a specific area? ☐ Yes ☐ No If yes, where? _____

Do you have any pain below your elbow? ☐ Yes ☐ No

Do you have any neck pain? ☐ Yes ☐ No

Describe the type of pain symptoms you experience (check all that apply):

☐ Sharp/stabbing ☐ Throbbing ☐ Shooting ☐ Aching ☐ Cramping ☐ Stiffness

☐ Burning ☐ Tingling ☐ Numbness ☐ Dull

Do you experience any of the following symptoms? (check all that apply):

☐ Swelling ☐ Bruising ☐ Locking ☐ Catching ☐ Joint Instability ☐ Weakness

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

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

When did you first start treating your pain? ☐ <1 month ☐ 1-3 months ☐ 3-6 months ☐ >6 months

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 ☐ Other injections (Synvisc, PRP, Stem cells)

☐ Chiropractic care ☐ Pain management ☐ Other: _____

How often do you exercise? ☐ Daily ☐ 1-2d/wk ☐ 3-4d/wk ☐ >5 d/wk

What types of exercise do you usually do? _____

Please list all operations you have had (name and date):

_____

_____

_____

_____

Do you ☐smoke or ☐chew tobacco? (please check) ☐ 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 MRSA, 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.)

_____ _____ _____ _____

Is there a history of arthritis in your family? ☐ No ☐ Yes

Your Height:_____ Your Weight:_____

ALLERGIES: (Drugs, Foods, etc.)	REACTIONS/Side Effects

Patient Name: _____ Date of Birth: _____

Medication Information

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 for TAKING

Review of Systems

In the **past month** have you experienced any of the following problems? Please circle all that apply:

□ Infections	□ Sore throat	□ Nausea/vomiting	□ Sore joints
□ Fever	□ Cough	□ Constipation/diarrhea	□ Muscle aches
□ Chills	□ Swollen glands	□ Abdominal pain	□ Poor sleep
□ Night sweats	□ Shortness of breath	□ Ulcers	□ Skin rash
□ Fatigue	□ Chest pain	□ Kidney/bladder problems	□ Depression
□ Weight loss	□ Fainting	□ Urination problems	□ Anxiety
□ Weight gain	□ Swollen feet	□ Bleeding problems	□ Headaches

Other: _____

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

Patient Name: _____ Date of Birth: _____

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: _____ Date of Birth: _____

*At ORTHOPAEDIC SPECIALISTS OF SCOTTSDALE, we 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.