Orthopaedic Specialists of Scottsdale

Return Patient Medical History – Upper Extremity

Last Name: ____________________________ First Name: ___________________________ MI: _______

Date of Birth: _______________ Age: _______ Occupation: ______________________ Retired? ☐ Yes ☐ No

Mailing Address: ________________________________ City: ______________________ St:___ Zip: ________

Home Phone: _____________________________________ Cell Phone: ______________________________

Primary Care Doctor: _______________________________ Pharmacy Number? ______________________

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 check)

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 ☐ N/A

Do you have any neck pain? ☐ Yes ☐ No ☐ N/A

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

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

☐ Burning ☐ Tingling ☐ Numbness ☐ N/A

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 ☐ N/A

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 to you usually do? ______________________________________

Any **new** medications from last visit? (Inc. Vitamins and supplements):

Medication Name	Dose	Frequency	Reason for Taking

Any **new** medications that you are **allergic** to, and the reaction you experienced to the medication from the last visit:

Allergies: (drugs, food, etc.)	Reaction/side Effects

Any **new** operations you have had from the last visit? (name and date):

Date	Name of the Operation

Patient Name:____ Date of Birth: ____________________

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

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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**

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: ____

*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.