ALIGNED ORTHOPEDIC PARTNERS

MEDICAL HISTORY FORM: UPPER EXTREMITY

Name: Age: Gender: ☐ M ☐ F Appointment date:

REASON FOR VISIT

What is the reason for your visit today? (Please include all relevant details)

Location: ☐ Right ☐ Left ☐ Bilateral (Both Left & Right)

Which is your dominant hand? ☐ Right ☐ Left ☐ Neither (Ambidextrous)

Context: Is this the result of an injury? ☐ Yes ☐ No

If **YES**, what type of injury?
- ☐ Sports injury: What sport? _____
- ☐ Car accident (MVA)
- ☐ Other: _____

Date of injury: _____

Work related: Did this injury occur while working? ☐ Yes ☐ No

Date of injury: _____

Duration: How long have you had this problem?

Onset: How quickly did the pain start?
- ☐ Suddenly (Immediate onset, as in an injury)
- ☐ Gradual (slowly, over time)

Status: How has the pain changed?
- ☐ Improving ☐ Resolved ☐ Stable
- ☐ Worse

Frequency: How often is the pain present?
- ☐ Intermittent (comes and goes) ☐ Constant ☐ Rare

Intensity: On a scale of 1-10 (10 being the most painful), how severe is the pain?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Quality: How would you describe the pain?
- ☐ Aching ☐ Burning ☐ Dull
- ☐ Sharp ☐ Throbbing ☐ Pinching

Aggravated by (what makes the pain worse?)
- ☐ Nothing ☐ Lifting ☐ Overhead
- ☐ Throwing ☐ Reaching back ☐ Gripping
- ☐ Writing / Typing ☐ Activity ☐ Work
- ☐ Other: _____

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Relieved by (what makes the pain better?)

- ☐ Nothing
- ☐ Brace/splint
- ☐ Elevation
- ☐ Exercise
- ☐ Ice
- ☐ Injections
- ☐ Massage
- ☐ Physical Therapy
- ☐ Stretching
- ☐ Rest
- ☐ Other: _____

Do you have any of the following associated symptoms?

Decreased mobility (stiffness)	☐ Yes	☐ No	Numbness	☐ Yes	☐ No
Instability (giving away)	☐ Yes	☐ No	Popping or clicking	☐ Yes	☐ No
Locking (stuck in position)	☐ Yes	☐ No	Swelling	☐ Yes	☐ No
Night pain	☐ Yes	☐ No	Weakness	☐ Yes	☐ No

Have you used any medication for this problem? ☐ Yes ☐ No

Anti-inflammatory medications -
Please list *(e.g. Ibuprofen, Advil, Aleve)*:

Pain (prescription) medications - Please list:

Does the medication relieve your pain? ☐ Yes ☐ No ☐ Temporarily/Partially

Imaging: Have you had any of the following?

- ☐ X-rays
- ☐ MRI
- ☐ CAT scan
- ☐ Doppler U/S
- ☐ EMG/NCV
- ☐ Bone Density

Date/Location of Imaging: _____

Unsuccessful treatments: What previous treatments have you tried that have been unsuccessful?

- ☐ Nothing
- ☐ Brace/splint
- ☐ Exercise
- ☐ Heat
- ☐ Ice
- ☐ Massage
- ☐ Rest
- ☐ Physical Therapy
- ☐ Injection

History: In the past have you ever had another problem to this same part of your body? ☐ Yes ☐ No

If **YES**, please list the date(s), type of evaluations and/or treatments and whether or not your symptoms were resolved.

Have you had any previous surgery for this condition? ☐ Yes ☐ No

If **YES**, please list the date(s) and type of evaluations and/or treatments

Additional History

Please list any other details about your pain or injury that have not been covered above