Orthopaedic Specialists of Central Arizona

Judah D Pifer, MD • Brad D Williams, MD

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 body part are you being seen for today? _____

Have you seen a doctor for this problem before? No ☐ Yes ☐ If yes, who? _____

Were images taken? (X-ray or MRI) No ☐ Yes ☐ If yes, where? _____

Did a specific injury or accident start your symptoms? No ☐ Yes ☐ Is Injury Work-Related? No ☐ Yes ☐

If yes, when was it how did the injury/ accident occur? _____

_____

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

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

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

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

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

☐ Burning ☐ Tingling ☐Numbness

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 pain better

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

Do you have any neck pain? ☐ Yes ☐ No

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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.
Have you tried or been prescribed any of the following for this problem?

Anti-inflammatory medications? (Tylenol, NSAIDs, glucosamine, supplements, etc.)

No ☐ Yes ☐ If yes, which _____ and for how long? _____

Narcotics or Pain Management for this specific issue?

No ☐ Yes ☐ If yes, which _____ and for how long? _____

Where is/ was this? _____

Physical Therapy? (Please provide visit notes or documentation if available.)

No ☐ Yes ☐ If yes, for how long? _____ where? _____

Address/ Phone number if not a local facility: _____

Who referred you to Physical Therapy? _____

Injections? (Cortisone, Gel, HA, Euflexxa, Synvisc, Gelsyn, etc.)

No ☐ Yes ☐ If yes, which _____ and for how long? _____

Where did you have these done? _____

Are there any changes in medications, allergies, or new surgeries since your last visit? Please list:

_____
_____
_____
_____
_____
_____

Height: _____ Weight: _____

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: _____

*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.

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Patient Name: _____ Date of Birth: _____

How often do you exercise? ☐Daily ☐1-2d/wk ☐3-4d/wk ☐>5 d/wk
What types of exercise do 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 illegal 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: _____

What diseases, if any, are common in your family? (i.e. diabetes, heart attacks, cancer, etc.)
_____

Please indicate any and all medical conditions for which you have been treated:

Under current active or past treatment?	Current	Past	*Under current active or past treatment?*	Current	Past
Heart disease or heart attack (*circle*)			Diabetes		
Congestive Heart Failure			Bladder infection		
Irregular Heartbeat			Liver Disease or Cirrhosis (*circle*)		
Hypertension (High Blood Pressure)			Kidney disease		
Bleeding Problems/ Anemia (*circle*)			Osteoporosis (weak bones)		
Blood clots in your legs or lungs (*circle*)			Rheumatoid Arthritis		
Pacemaker			Severe body aches/Fibromyalgia (*circle*)		
Stroke			COPD/ Emphysema/ Bronchitis (*circle*)		
Stomach/ Intestinal Ulcer (*circle)*			Sleep Apnea		
Gastritis/ Reflux Disease (*circle)*			MRSA Infection		
Leukemia/ Lymphoma (*circle*)			Tuberculosis		
Thyroid Disease			HIV/AIDS		
Prostate Difficulty			Rheumatoid Arthritis		
Medical Implants:			Other:		

Please list any medical implants: _____

Please list any operations you have had (names and dates):
_____
_____
_____
_____

By signing below, I certify that I have understood the questions and have answered honestly and to the best of my knowledge.

Signature:_____ Date: _____

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Patient Name: _____ Date of Birth: _____

ALLERGIES: Drugs/Foods	REACTIONS or SIDE EFFECTS	ALLERGIES: Drugs/Foods	REACTIONS or SIDE EFFECTS

Please list all medications you currently take including: Prescriptions, Over-the-Counter, Patches, Inhalers, Vitamins, Herbal Supplements, Eye Drops, and Injections.

DRUGNAME	DOSE	FREQUENCY	REASON

By signing below, I certify that I have understood the questions and have answered honestly and to the best of my knowledge.

Signature:_____ Date: _____

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Medical Information (HIPAA) Release Form

This form MUST be completed in its entirety.

Name: _____

DOB: _____ SSN: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Physical Address: _____ City: _____ St: _____ Zip: _____

How may we contact you?

Primary Phone #: _____ Main/ Home/ Cell May we leave a message? Yes / No

Secondary Phone #: _____ Main/ Home/ Cell May we leave a message? Yes / No

Email: _____

Do you have an Advanced Directive (Living Will) Yes / No

If yes, please bring a copy with you to your appointment

I acknowledge and am aware of the Notice of Privacy Practices: ☐ Yes ☐ No

Emergency Contact(s):

1. _____ Relationship: _____ Phone: _____

2. _____ Relationship: _____ Phone: _____

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information to the following:

☐ Spouse / Significant Other: _____

☐ Children: _____

_____

☐ Other: _____

☐ Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

Signature: _____ Date: _____
(Patient or legally authorized individual)

Printed Name: _____

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Patient Name: _____DOB: _____

Consent for Treatment:

I authorize performance of necessary medical and/or surgical treatments. These medical services are to be performed by a licensed medical professional and/or appropriate staff of their choicein the medical facility of their choice. (i.e. office, hospital, outpatient facility, etc.}

If patient is a minor, who is authorizing treatment:

Name: _____DOB: _____

SSN: _____ Relationship: _____

Driver's License: _____ Phone: _____

I hereby authorize the above listed providers to furnish information to Insurance Carriers/Workers Compensation concerning my illness and treatments and information needed to determine benefits or benefitsfor related services. I hereby authorize payment of insurance benefits directly to the above listed billing provider. I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I further agree to pay all collection fees, attorney fees and other collection costs that may be incurred to enforcecollection of any amount outstanding.

I request that payment of authorized Medicare Benefits be made directly to the above listed billing provider forany services furnished to me by that provider. I authorize the holder of medical information about me to releaseto the Health Care Financing Administration and its agents any information needed to determine these benefitsor the benefits payable for related services.

I hereby authorize the release of medical records to and from all hospitals, medical service companies, insurancecompanies and other physicians assisting in the care of the patient. Authorization is also given for a copy of office notes to be mailed to the patient if requested.

Signature: _____ Date: _____

(Patient or legally authorized individual)