

SEAPORT ORTHOPAEDIC ASSOCIATES

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New Patient Upper Extremity Questionnaire

The following questions are part of an initial visit, and are essential. All information provided is kept confidential.

If you are an old patient of this office, but this is a new injury, or a new problem, we request that you complete a new questionnaire to update your medical information.

Date of exam: _____

Patient Name: _____

Date of Birth: _____ **Age:** _____

Male: _____ **Female:** _____ **Right Handed** _____ **Left Handed** _____

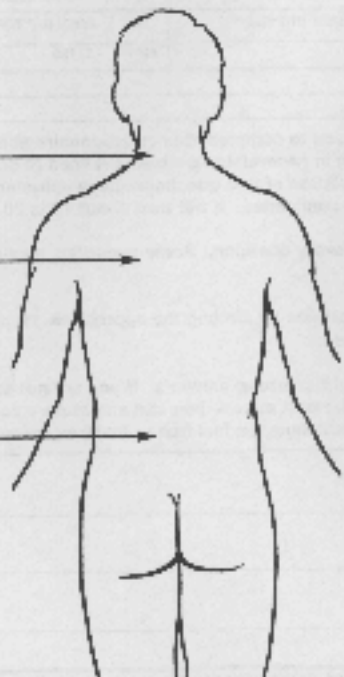
OCCUPATION _____

Date of injury, if a traumatic injury: _____

Primary reason for today's visit:

Referred to this office by:

<p>For your right side please indicate those areas that bother you or limit your function.</p>	<p>For your left side please indicate those areas that bother you or limit your function.</p>
<p>Neck <input type="checkbox"/></p>	<p>Neck <input type="checkbox"/></p>
<p>Shoulder area <input type="checkbox"/></p>	<p>Shoulder area <input type="checkbox"/></p>
<p>Elbow/Forearm <input type="checkbox"/></p>	<p>Elbow/Forearm <input type="checkbox"/></p>
<p>Wrist/Hand <input type="checkbox"/></p>	<p>Wrist/Hand <input type="checkbox"/></p>
<p>Hip <input type="checkbox"/></p>	<p>Hip <input type="checkbox"/></p>
<p>Thigh <input type="checkbox"/></p>	<p>Thigh <input type="checkbox"/></p>
<p>Knee area <input type="checkbox"/></p>	<p>Knee area <input type="checkbox"/></p>
<p>Calf area <input type="checkbox"/></p>	<p>Calf area <input type="checkbox"/></p>
<p>Ankle/Foot area <input type="checkbox"/></p>	<p>Ankle/Foot area <input type="checkbox"/></p>

<p>For your back please indicate those areas that bother you or limit your function.</p>	
<p>Neck <input type="checkbox"/></p>	
<p>Upper Back <input type="checkbox"/></p>	
<p>Lower Back <input type="checkbox"/></p>	

General Health

This section is about your general health, and not specifically about your upper extremity problems. However, it is necessary to review both past and present medical problems, if any.

Have you ever been hospitalized? NO _____ YES _____

If yes, when _____

For Surgery NO _____ Yes _____

Procedure(s) with dates

Childbirth NO _____ Yes _____

In general how would you rate your health:

- _____ Excellent
- _____ Very Good
- _____ Good
- _____ Fair
- _____ Poor

Separate from your upper extremity problems, does any other health issue limit your activities:

_____ YES _____ NO

If yes, how? _____

Do you have now or in the past:

Does an immediate
family member have?
FAMILY

PATIENT

_____ Heart Disease	_____
_____ High Blood Pressure	_____
_____ Lung Disease-Asthma	_____
_____ Diabetes or elevated blood sugar	_____
_____ Ulcer or Stomach diseases	_____
_____ Irritable bowel disease	_____

PATIENT

FAMILY

- _____ Gall Bladder disease _____
- _____ Prostate disease(enlargement or cancer) _____
- _____ Kidney Disease _____
- _____ Liver Disease _____
- _____ Anemia or blood disease, bleeding problems _____
- _____ Cancer _____
- _____ Depression _____
- _____ Osteoarthritis _____
- _____ Rheumatoid arthritis _____
- _____ Connective tissue diseases(lupus,scleroderma) _____
- _____ Back Pain/neck pain _____
- _____ other illness _____

Medications

Do you currently take any prescription medications? Over the counter supplements?

If so please list:

_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medication: _____ YES _____ NO

If Yes, please list the medication and its effect:

INJURY AT OR RELATING TO WORK

This section is to be completed if you were injured while working.

Did you get hurt at work? Yes No

When? Date of Injury or accident _____

if no specific date, i.e. a cumulative injury situation, please use the filing date, if known, otherwise "OD"

Has your employer submitted a injury report? Yes No.

If no, why not?

How did your work related activities cause an injury? Be as specific as possible: check all that apply:

- abrasion amputation bite burn
- contusion crush dislocation fracture
- laceration puncture wound repetitive strain sprain/strain
- torn ligament, tendon or muscle.

Please give details:

Is there any other documentation available describing the injury? Check all that apply:

- Medical records Accident reports

Are you currently working Yes No

Describe your job: _____

If you are not working, why not?

HISTORY OF CURRENT PROBLEM
All patients to complete

What is the specific reason for this visit?

When did you first become aware of your upper extremity problem? DATE: _____

Sudden Onset? _____ Yes _____ No

If sudden onset, was there an injury or accident? _____ Yes _____ No

If yes and If work or motor vehicle related, please complete those sections also. If not, please describe the details of the accident or injury:

Have you been to the emergency room or a hospital ___ YES ___ NO

When _____ Which hospital _____

What was done at the hospital?

X-rays ___ yes ___ no

If yes, results:

Treatment check all that apply and give details:

___ cast ___ splint ___wound closed, sutured ___ Prescriptions

___ surgery ___ hospital admission

Details of treatment:

Have you seen another physician(s) for this problem?

name(s): _____

Have you had previous tests: (check all that apply)

___ MRI ___ x-ray ___ CT Scan ___ EMG/NCV

Previous treatment: ___ medication ___ surgery ___ therapy ___ splints or casts

Have you obtained relief with the previous treatment?

___ yes ___ no ___ partial

Details:

If not an accident:

Gradual Onset ___ Yes ___ No Sudden Onset ___ yes ___ no

Are you currently in pain? ___ yes ___ no

If yes, on a 1- 10 scale your current pain is a _____

Where is your worst pain

Do you have? (check all that apply)

_____ numbness/tingling
_____ pain
_____ stiffness
_____ swelling
_____ weakness
_____ loss of dexterity

Have you had to modify your activities because of your upper extremity problems?

yes no

if yes, have you changed or modified any of the following:

- work
- sports
- playing a musical instrument
- using a computer
- using a cell phone, pda or blackberry
- exercising(weight lifting, yoga, etc.)
- household activities(cleaning,cooking)

THANK YOU FOR COMPLETING THIS FORM. THE INFORMATION YOU HAVE PROVIDED WILL ASSIST IN DETERMINING YOUR OPTIMAL TREATMENT.