

Date of Visit _____
Initial Patient Visit- UE

PATIENT'S NAME _____ DATE OF BIRTH ____/____/____ AGE ____ SEX: M F

Who referred you to us? _____

Family Physician: _____ Physician's Phone Number _____

What brings you to our office today/ How can we help you?

What kind of problem is it?

- Fracture
- Dislocation
- Laceration / cut / wound: tendon nerve muscle
- Sprain
- Pain
- Numbness
- Weakness
- Stiffness
- Instability of joint
- Swelling

Was there an accident or event that started it? Yes No

If yes, please describe: _____

For how long/when was it? ____Days ____Months ____Years

Was it at work? Yes No

Where **exactly** is this problem located-where does it bother you?

Left hand

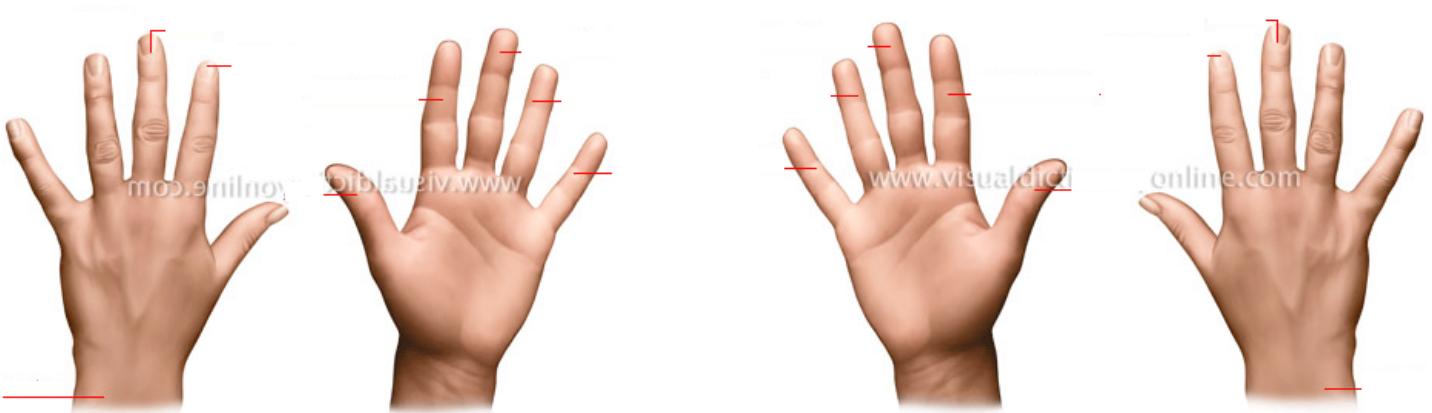
back

palm

Right hand

palm

back



Inside of Elbow / Arm



Outside of Elbow / Arm



What activities/tasks/motions seem to make it worse? _____

What do you do for work? _____

Any activities that you do or issues that this problem puts at risk? _____

What has been done in your treatment, by whom, and how long ago?

Medicines:	who gave it to you	timing
<input type="checkbox"/> Ibuprofen, naproxen	_____	_____
<input type="checkbox"/> Tylenol	_____	_____
<input type="checkbox"/> Medrol dose pack/steroids by mouth	_____	_____
<input type="checkbox"/> Vicodin, Percocet, other narcotics	_____	_____
<input type="checkbox"/> Other _____	_____	_____

Diagnostic tests	who ordered it for you
<input type="checkbox"/> X rays	_____
<input type="checkbox"/> CT	_____
<input type="checkbox"/> MRI	_____
<input type="checkbox"/> EMG/Nerve conduction studies	_____

Interventions	who gave it to you/did the procedure	timing
<input type="checkbox"/> Steroid injection	_____	_____
<input type="checkbox"/> Aspiration	_____	_____
<input type="checkbox"/> Therapy	_____	_____
<input type="checkbox"/> Previous surgery	_____	_____

What are your expectations for today's visit /what do you hope is done? _____

Medical Conditions: Have you or your family ever sought medical treatment for any of the following problems?

	Self		Parent	Sibling
	Yes	No		
Weight Loss				
Fever, Chills				
Vision Problems				
Hearing problems				
Headaches				
Stroke				
Hallucinations				
Heart Disease				
Heart Attack				
High Blood Pressure				
Lung Disease				
TB				
Emphysema				
Asthma				
Sleep apnea				
Stomach Ulcer				
Colitis				
Difficulty in Urinating				
Kidney Disease				
Arthritis				
Gout				
Osteoporosis				
Rheumatoid Arthritis				
Parkinson's Disease				
Seizures				
Diabetes				
Thyroid Disorder				
Bleeding Problems				
Sickle Cell Anemia				
HIV				
Hepatitis				
Cancer (note type)				

SOCIAL HISTORY

Do you smoke? (Complete if age 12 and greater)

- NO If you have quit smoking, when did you quit? (Month and year) _____
- YES Number of packs per day _____ Number of years smoking _____

Do you use smokeless tobacco? (Complete if age 12 and greater)

- NO If you quit smokeless tobacco, when did you quit? _____
- YES What do you use? _____ Number of years using smokeless tobacco? _____

Do you drink alcoholic beverages? NO YES HOW OFTEN

- 1 DRINK PER MONTH 1-2 DRINKS PER WEEK 2-6 DRINKS PER WEEK 6 DRINKS OR MORE PER WEEK

Do you use recreational drugs? NO YES (Please list) _____

Patient/Guarantor Signature: _____ Date: _____

All items on this page were reviewed by _____ (MD/PA initials) on _____ (date).