COASTAL ORTHOPEDICS

UPPER EXTREMITY ESTABLISHED PATIENT MEDICAL HISTORY UPDATE

Date of visit: ____ /____ /____ **Who are you seeing today:_____**

YOUR INFORMATION

Full name: _____

Date of birth: ____ /____ /_____

Height: _____ **Weight:** _____

Hand dominance: ☐ Right ☐ Left ☐ Ambidextrous

Primary care physician:

PLEASE INDICATE ANY NEW MEDICATIONS SINCE LAST VISIT

Are you currently, or will you be initiating, the use of Medical Marijuana for any reason? ☐ Yes ☐ No

Are you taking Aspirin or any other blood thinners? ☐ Yes ☐ No

☐ Yes ☐ No **I consent to securely pull my medications from the pharmacy database, and reconcile with the Medical Assistant**

List all the medications you take, both prescription & nonprescription below:

☐ **No medications to list** ☐ **See attached list of medications**

Medication or Brand Name	Dose	Medication or Brand Name	Dose

YOUR ALLERGIES

☐ **No new allergies** **Indicate all the allergies you have to medications and/or food & describe reaction below:**

Common reactions include – Anaphylaxis (Life Threatening), Hives, Itching, Nausea/Vomiting, Trouble Breathing

PLEASE INDICATE ANY NEW MEDICAL HISTORY SINCE LAST VISIT

☐ **No new relevant medical history**

☐ Hypertension	☐ Kidney disease	☐ Obesity	☐ AIDS/HIV
☐ Heart disease: _____	☐ Diabetes – I or II	☐ Peripheral vascular disease	☐ Ulcers
☐ Osteoarthritis	☐ Osteoporosis	☐ Anxiety	☐ DVT/blood clots
☐ Rheumatoid arthritis	☐ Cancer– Type: _____	☐ Depression	☐ Stroke

Any additional medical history information:

SURGICAL HISTORY SINCE LAST VISIT

☐ **No new surgical history**

☐ Hip replacement – RT/LT	Date: ____/____/_____	☐ Fracture – Type: _____	Date: ____/____/_____
☐ Knee replacement – RT/LT	Date: ____/____/_____	☐ Pacemaker	Date: ____/____/_____
☐ Shoulder/rotator cuff – RT/LT	Date: ____/____/_____	☐ Open heart/by-pass	Date: ____/____/_____
☐ Carpal tunnel – RT/LT	Date: ____/____/_____	☐ Spine – type/level: _____	Date: ____/____/_____
☐ Arthroscopy – Type: _____	Date: ____/____/_____	☐ Other: _____	Date: ____/____/_____

Any additional surgical information:

DIAGNOSTIC HISTORY SINCE LAST VISIT

Study	Date	Results
X-RAYS	_____ /_____ /_____	
MRI/CT	_____ /_____ /_____	
EMG/nerve conduction studies	_____ /_____ /_____	
Myelogram	_____ /_____ /_____	
Bone scan / DEXA scan	_____ /_____ /_____	

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YOUR SOCIAL HISTORY

Tobacco Use: ☐ Current ☐ Former ☐ Never **If Current**, have you ever tried to quit? ☐ Yes ☐ No

Type: _____ Packs/Day: _____ Years used: _____

Alcohol Use: ☐ Yes ☐ No ☐ Former **If Yes**, select type: ☐ Beer ☐ Wine ☐ Liquor

Frequency: _____ Amount per sitting: _____ Last drink: _____

Which of the following drugs or substances. if any, have you used in the PAST? (Please check all that apply)

☐ None ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other:_____

Are you PRESENTLY using any of the following drugs or substances? (Please check all that apply)

☐ None ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Other:_____

REVIEW OF SYSTEMS

☐ **All Negative Below** **Check if you have any of the following:**

General	Cardiovascular	Metabolic	Skin
☐ Fever	☐ Heart murmur	☐ Cold intolerance	☐ Rash
☐ Weakness	☐ Leg swelling/edema	☐ Heat intolerance	☐ Skin infections
☐ Weight gain/loss (circle one)	☐ Syncope/fainting		☐ Skin lesions
Ears, Nose & Vision	**Gastrointestinal (GI)**	**Neurological**	**Blood Disorders**
☐ Blurred vision	☐ Constipation	☐ Difficulty walking	☐ Bleeding
☐ Facial pain	☐ Diarrhea	☐ Dizziness	☐ Bruising
☐ Headache	☐ Nausea	☐ Poor coordination	
☐ Vertigo/dizziness	☐ Vomiting	☐ Muscle weakness	
Respiratory	**Urinary**	**Psychiatric**	**Immune System**
☐ Dyspnea (difficulty breathing)	☐ Dysuria (difficulty urinating)	☐ Anxiety	☐ Asthma
☐ Recent infections	☐ Frequent urination	☐ Depression	☐ Environmental allergies
☐ Wheezing	☐ Hematuria (blood in urine)	☐ Insomnia	☐ Food allergies

YOUR ATTESTATION

I attest that the information provided above is complete & accurate as it will be utilized as part of my care and treatment plan.

Patient signature: **Date:** ____ /____ /____

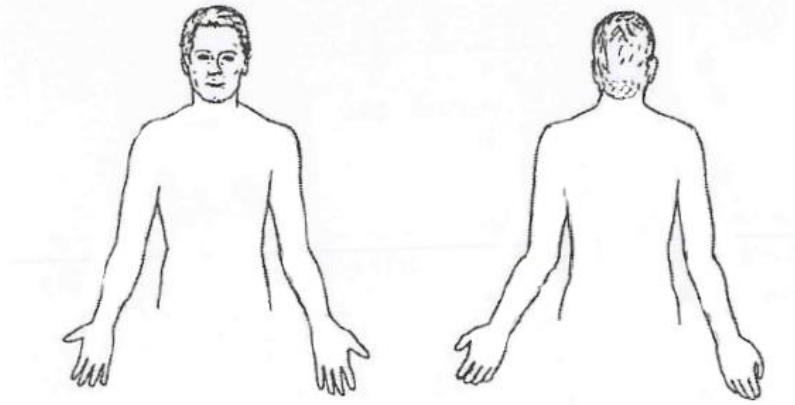
If minor, guardian signature: **Date:** ____ /____ /____

COASTAL ORTHOPEDICS

UPPER EXTREMITY CONDITION

Patient name: _____ Date of birth ___/___/_____ Today's date___/___/_____

Tell us about the reason for your visit today
What is the reason for your visit today?
When did this condition start (onset)?
Place of injury? ☐ Sports ☐ Home ☐ Auto Accident ☐ Workplace ☐ School ☐ Non-applicable
How often does the condition occur? ☐ Rare ☐ Intermittent ☐ Occasional ☐ Persistent
What is the status of your condition since the onset date? ☐ Unchanged ☐ Improving ☐ Fluctuating ☐ Stable ☐ Worse ☐ Resolved
What is the severity of your pain/numbness at its worst? (Circle a number) No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Incapacitating
What type of pain are you experiencing? Check all that apply.
☐ None ☐ Ache ☐ Burning ☐ Discomfort ☐ Dull ☐ Numbness ☐ Piercing ☐ Sharp
☐ Shooting ☐ Stabbing ☐ Electric ☐ Deep ☐ Throbbing ☐ Tearing ☐ Localized ☐ Diffuse
Location of Pain: *On the diagram below **"SHADE"** all areas where you feel pain and **"X" the areas that hurt the most***



Is your condition aggravated by? Check all that apply						
☐ Nothing	☐ Daily activity	☐ Movement	☐ Pushing	☐ Pulling	☐ Lifting weight	☐ Carrying items
☐ Showering	☐ Getting dressed	☐ Rotation/ twisting	☐ Sleeping/ lying down	☐ Bending	☐ Grasping an object	☐ Occupational therapy
☐ Weather changes	☐ Exercise	☐Other: _____				

Is your condition relieved by? Check all that apply						
☐ Nothing	☐ Ice	☐ Heat	☐ Elevation	☐ Mobility	☐ Rest	☐ Stretching
☐ Exercise	☐ Brace	☐ Massage	☐ Physical therapy	☐ Injection	☐ Over the counter meds	☐ Pain medication

Tell us about any past medical treatment

☐Never been treated for condition	Start Date	☑ Receiving now	End Date	Name of facility where treatment was completed	% of relief 0-100
Activity modification	___/___/____	☐	___/___/____		
Bracing	___/___/____	☐	___/___/____		
Injection/nerve block	___/___/____	☐	___/___/____		
Drug/medication therapy	___/___/____	☐	___/___/____		
Physical therapy	___/___/____	☐	___/___/____		
Physician prescribed home exercise	___/___/____	☐	___/___/____		
Resting the area	___/___/____	☐	___/___/____		
TENS unit	___/___/____	☐	___/___/____		
Other: _____	___/___/____	☐	___/___/____		