

**RESURGENS ORTHOPAEDICS**  
**UPPER EXTREMITY MEDICAL INFORMATION QUESTIONNAIRE**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_ Self referral

Age: \_\_\_\_\_ Are you right handed or left handed? Right Left Both Sex: Male Female

Which upper extremity is bothering you most? Right Left Both

Which part of your arm is bothering you? Shoulder Elbow Forearm Wrist Hand  
Finger(s): Thumb Index Long Ring Small

Which of the following best describes your main problem(s)?

Pain Weakness Deformity Instability Abnormal motion Abnormal sensation

Mass Swelling Laceration

Other: \_\_\_\_\_

Date of injury or first symptoms: \_\_\_\_\_ Where did symptoms begin? Home Work Other

How did your symptoms begin or how did your injury occur?

\_\_\_\_\_

Are the symptoms: Constant or Intermittent

Since your symptoms started, have they been getting: better worse staying the same

What makes your symptoms better? \_\_\_\_\_ Nothing

What makes your symptoms worse? \_\_\_\_\_ Nothing

What is your pain level? 0 1 2 3 4 5 6 7 8 9 10  
None Severe

Have you ever had similar symptoms in the past? Yes No When: \_\_\_\_\_

Have you seen another doctor for this problem? Yes No

If yes, name of doctor(s): \_\_\_\_\_

What was your diagnosis? \_\_\_\_\_

What treatments have you had? \_\_\_\_\_

Did the treatment help? Yes No Partially

Is a lawyer handling your claim? Yes No

What is your occupation? \_\_\_\_\_

Where are you employed? \_\_\_\_\_

Are you currently working? Yes No If yes, regular or light duty? Regular Light

**ALLERGIES**

Do you have any **ALLERGIES**? Yes No

If yes, please list all allergies: \_\_\_\_\_

Are you allergic to latex? Yes No      Have you had any anesthetic reactions? Yes No

**MEDICATIONS**

Are you currently taking any medications? Yes No

I If yes, please list all medications and dosages: \_\_\_\_\_

**PAST MEDICAL HISTORY** Please circle any of the following conditions that you have or have had.

- |                           |                          |                  |                   |
|---------------------------|--------------------------|------------------|-------------------|
| Diabetes                  | Hypertension             | Lung disease     | Bleeding problems |
| Thyroid disease           | Heart disease            | Asthma           | Seizures          |
| Rheumatoid arthritis      | Mitral valve prolapse    | Emphysema        | Stroke            |
| Osteo arthritis           | Irregular heart beat     | Steroid use      | Osteoporosis      |
| Connective tissue disease | Psoriasis                | Gout             | Blood clots       |
| Stomach ulcers or problem | HIV/AIDS                 | Colitis          | Hepatitis         |
| Reflux                    | Cancer                   | Kidney infection | Blood transfusion |
| Ear, nose, throat problem | Numbness/balance problem | Kidney failure   | Mental illness    |
| Sleep apnea               | Other: _____             |                  |                   |
- Are you pregnant? Yes No N/A

**PAST SURGICAL HISTORY** Please list previous surgeries and the year(s) they were performed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

- |  |              |          |                               |                |
|--|--------------|----------|-------------------------------|----------------|
| Marital Status:                            | Singled      | Married  | Divorced                      | Widowed        |
| Do you use tobacco?                        | Yes          | No       | How many packs per day? _____ |                |
| Do you drink alcohol?                      | Yes          | No       | How much? _____               |                |
| Do you use any illegal drugs?              | Yes          | No       |                               |                |
| What hobbies/sports do you participate in? | Golf         | Tennis   | Running                       | Weight lifting |
|  | Swimming     | Baseball | Football                      | Basketball     |
|  | Other: _____ |          |                               |                |

**FAMILY HISTORY** Does you family have any history of:

- |           |               |                   |                            |
|-----------|---------------|-------------------|----------------------------|
| Diabetes  | Heart disease | Blood clots       | Thyroid disease            |
| Cancer    | Hypertension  | Bleeding problems | Stroke                     |
| Arthritis | Hepatitis     | Lung disease      | Connective tissue disorder |
| HIV/AIDS  | Stomach/Bowel | Kidney disease    | ETOH/drug abuse            |