Patient Medical History
Shoulder & Hand Therapy Center

Name: _____ Today's date: _____

Dominant hand: ☐ Right ☐ Left

Referring doctor's name: _____Next appointment: _____

Work Information

Are you currently employed? ☐ Full-time ☐ Part-time ☐ No ☐ Student ☐ Retired Job title: _____

List your normal job functions ? _____

Lifting: _____ _____ Pushing: _____ _____ Pulling: _____ _____ Overhead: _____ _____
Weight *How often* *Weight* *How often* *Weight* *How often* *Weight* *How often*

Current work status: ☐ Full-duty ☐ Light-duty ☐ Off-duty ☐ One-handed ☐ With restrictions of: _____

PAST MEDICAL HISTORY:

Please check if you are a ☐ Non-smoker ☐ Smoker

Please circle/list any past or current medical conditions:

Heart disease	High blood pressure	Stroke	Diabetes: 1 or 2; Complications:
Pacemaker/Defibrillator	Irregular heart rate	COPD	Arthritis: Osteo or Rheumatoid
Gout	Neck pain	Back pain	Cancer, type: Year:
Head injury, date:	Other:		

In general, would you say your overall health right now is…O Excellent O Very good O Good O Fair O Poor

Please list any previous neck, shoulder, arm, or hand injuries and/or surgeries:

_____Date: _____

_____Date: _____

Do you have any metal implants or artificial joints? ☐ Yes ☐ No; if yes please list: _____

Do you have any allergies? Please specify: _____

Please list ***ALL*** Medications, Over-the Counter medicines, Vitamin/Mineral Supplements & Herbal Supplements (even if you only take them occasionally as needed for headache, seasonal allergies, etc.):

Name	Dosage	Frequency	Type (please circle)
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:
			Tablet - Liquid - Injection - Other:

Continue on back if needed…

1) SYMPTOMS / CHIEF COMPLAINTS: (i.e. stiffness, weakness, pain, numbness, scarring, difficulty with …, etc.)

_____

_____

When did symptoms start? _____ What happened? _____

Date of surgery, if applicable: _____ Are you under any medical restrictions? ☐ Yes ☐ No

If yes, please list: _____

2) Describe your pain: _____ Where does it hurt? _____

Please rank your pain, zero is no pain and 10 is the worst pain:

At rest: (no pain) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (worst)

With/post activity: (no pain) ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (worst)

QuickDASH functional assessment questionnaire. Please answer every question based on your condition in the last week, making your best estimate of the most accurate response, regardless of which hand or arm you use to perform the activity.			
1. Difficulty opening a tight or new jar? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable	2. Difficulty doing heavy chores (wash floors, walls)? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable	3. Difficulty carrying a shopping bag or briefcase? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable	4. Difficulty washing your back? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable
5. Difficulty with activities that take some force or impact through your arm, shoulder, or hand (golf, hammering, tennis)? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable	6. During the past week, to what extent has your arm, shoulder, or hand problem interfered with your normal social activities with family, friends, neighbors, or groups? ① Not at all ② Slightly ③ Moderately ④ Quite a bit ⑤ Extremely	7. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder, or hand problem? ① Not at all ② Slightly ③ Moderately ④ Very ⑤ Unable	8. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand? ① None ② Mild ③ Moderate ④ Severe ⑤ So much that I can't sleep
9. Difficulty using a knife to cut food? ① None ② Mild ③ Moderate ④ Severe ⑤ Unable	10. Tingling (pins & needles) in your arm, shoulder, or hand? ① None ② Mild ③ Moderate ④ Severe ⑤ Extreme	11. Arm, shoulder, or hand pain? ① None ② Mild ③ Moderate ④ Severe ⑤ Extreme	*For office use:* *((_____/11) -1) x 25 =* *Todays' score:* _____

3) What are your goals for therapy? _____

_____

- Thank you -