PATIENT HISTORY
FOR RICHARD F. HOWARD, D.O.
(TO BE UPDATED ANNUALLY)

Name _____ Date _____

Social Security Number	Date of Birth	Age	Height	Weight

1) Who is your primary care physician? _____
   Address and/or phone number _____
2) Who referred you to this office? _____

3) Which extremity is involved? Right / Left _____
4) Are you RIGHT or LEFT handed? (Please Circle)
5) Please describe your problem/symptoms.

6) What do you believe to be the cause of your problem/symptoms? _____
   _____

7) When does the problem occur? _____

8) What treatment have you had for this problem? _____
   _____

9) How long have your problem/symptoms been present? _____

10) Did you have an injury? Yes _____ No _____ (if no, please go to question 12)
    Date of injury: ___/___/___ Where did the injury occur? _____at work _____sport _____other
    How did the injury occur? _____
    _____
    How was the injury treated? _____
    Who treated you? _____
    Results of treatment: _____

11) Have you had a previous injury or work related injury to this same area? Yes_____ No_____
    -Date of previous injury: ___/___/___ -How did it occur? _____
    -Residual symptoms: _____

    Occupation: _____
    Employer: _____ How long have you been at this job? _____

12) How much time have you missed from work? _____

13) Is this injury work-related? Yes___ No____

14) Is an Attorney working on your problem? Yes_____ No_____

15) Have you had any of the following?

	When?	Where?
X-rays		
MRI		
Nerve Studies		
CT Scan		
Bone Scan		

MEDICATION ALLERGIES:

LATEX ALLERGY: YES / NO

Medications	Dose

Any problems with Anesthesia? YES / NO
Are you on Blood Thinners currently? YES/NO

HOSPITALIZATIONS and SURGERIES	
Surgery	**Date**

Social History:

Are you married Yes / No
Number of years _____
Do you have children Yes / No
Number _____
What is your occupation? _____
Number of years _____
Do you smoke? Yes / No
Packs per day? _____
Do you drink alcohol? Yes / No
Drinks per week? _____
Any history of drug or alcohol abuse? Yes/No

Family History *(Check those that apply)*

	Self	Mom	Dad	Sibling
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Gout	☐	☐	☐	☐
HIV/ AIDS	☐	☐	☐	☐

Your Health History

In the past 30 days, have you experienced any of the following?
(PLEASE CIRCLE all that apply or CIRCLE NONE)

CONSTITUTIONAL - **NONE**
Fever Chills Weight Loss
Fatigue

EAR, NOSE, THROAT - **NONE**
Dizziness Sinus Problems Hoarseness
Vision Change Deafness Nose Bleeds

CARDIOVASCULAR - **NONE**
Palpitations Heart Murmur Chest Pains
Pacemaker

Are you under the care of a cardiologist? Yes / No

RESPIRATORY - **NONE**
Sleep Apnea Cough Shortness of Breath

GASTROINTESTINAL - **NONE**
Stomach Pain Nausea Constipation
Diarrhea Vomiting Blood in Stool
Appetite Loss Heartburn

GENITOURINARY - **NONE**
Frequent Urination Painful Urination Blood in Urine
Hesitancy Urgency

MUSCULOSKELETAL - **NONE**
Redness of Joints Joint Pains

ENDOCRINE - **NONE**
Excessive Thirst Decreased Energy

NEUROLOGIC - **NONE**
Headaches Seizures Speech Issues

PSYCHIATRIC - **NONE**
Depression Nervousness Anxiety

HEMATOLOGIC/LYMPHATIC - NONE
Bleeding Problems Easy bruising Blood Clots

SKIN - **NONE**
Rashes Itching

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*Quick*DASH – 9

Patient: _____ DOB: _____ Date: _____

INSTRUCTIONS: This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer each question, based on your condition in the ***LAST WEEK***, by circling the appropriate number. If you did not have the Opportunity to perform an activity in the past week, please make your best *ESTIMATE* of which response would be most accurate. It doesn't matter which hand or arm you use to perform the activity, please answer based on your ability regardless of how you preformed the task.

Rate your ability to do the following activities in the last week by circling the number below appropriate response.

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	UNABLE
Open a tight or new jar	0	1	2	3	4
Do heavy household chores (e.g: wash walls, floors)	0	1	2	3	4
Carry a shopping bag or briefcase	0	1	2	3	4
Wash your back	0	1	2	3	4
Use a knife to cut food	0	1	2	3	4
Recreational activities in which you take some force or impact through your arm, shoulder, or hand (e.g: golf, hammering, tennis, etc.)	0	1	2	3	4

	Not At All	Slightly	Moderately	Quite a Bit	Extremely
During the past week, to *what extent* has your Arm, shoulder, or hand problem interfered with your normal social activities with family, friends, etc.?	0	1	2	3	4

	Not At All	Slightly Limited	Moderately Limited	Quite a Bit	Extremely
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?	0	1	2	3	4

	None	Mild	Moderate	Severe	Extreme
Arm, shoulder, or hand pain	0	1	2	3	4

AQuickdash-9 score may not be calculated if there is greater than 1 missing item. QuickDash -9 score – ({sum} x1.2) x 5.2, a missing response is added as the average of the remaining

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Pain Level Shortly After Injury

* Circle the number on the line below that represents your pain at its least.

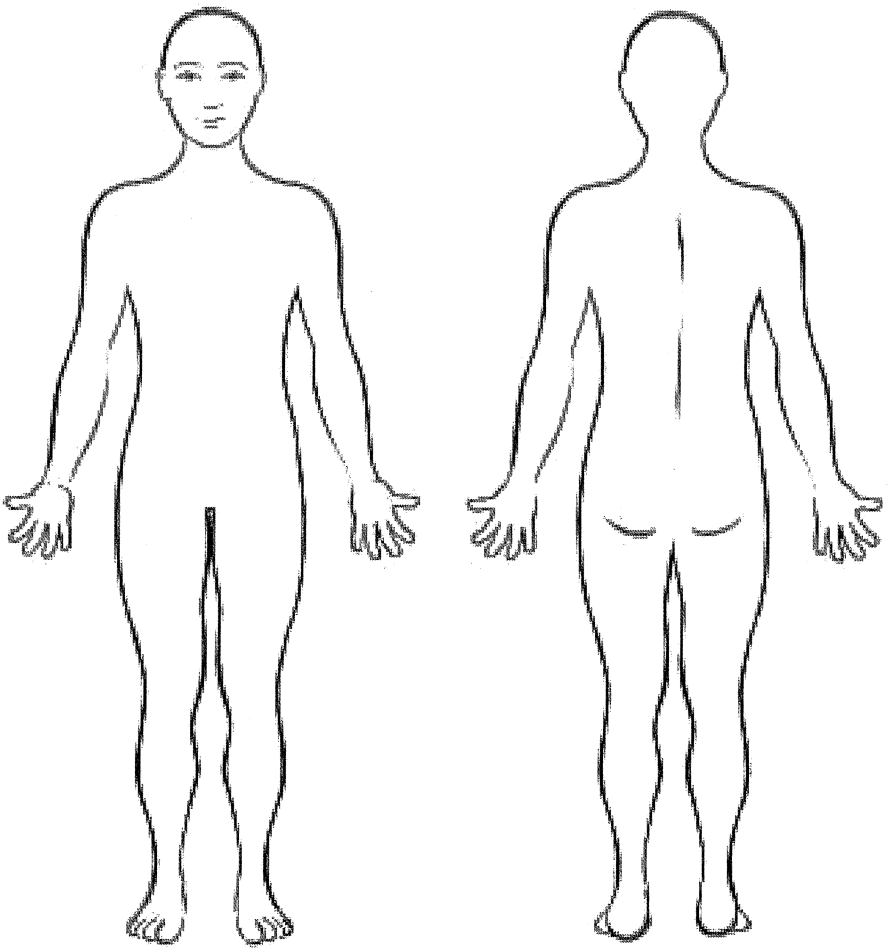
* Circle the number on the line below that represents your pain at its worst.

* Place an "X" on the line below that represented your pain **shortly after the injury**.

0	1	2	3	4	5	6	7	8	9	10
No Pain			**Moderate**			**Severe**				**Excruciating**

Indicate on the diagram below where your pain was located and what type of pain you were experiencing **shortly after the injury** **(If there was no injury, skip to the next page).** Use the symbols to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

>>> Sharp
/// Stabbing
XXX Burning
OOO Pins & Needles
==== Numbness or Tingling
+++ Aching



Pain Level Today

* Circle the number on the line below that represents your pain at its least.
* Circle the number on the line below that represents your pain at its worst.
* Place an "X" on the line below that represents your pain **right now**.

0	1	2	3	4	5	6	7	8	9	10
No Pain			**Moderate**			**Severe**				**Excruciating**

Indicate on the diagram below where your pain is located and what type of pain you feel **at the present time**. Use the symbols to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

>>> Sharp
/// Stabbing
XXX Burning
OOO Pins & Needles
==== Numbness or Tingling
+++ Aching