MEDICAL SCREENING FORM

Elbow, Wrist, or Hand Pain

REASON FOR VISIT

Nature of your illness/injury:____________________

Date of Onset/Surgical Date:____________________

MAJOR ILLNESS/SURGICAL HISTORY

Date:__________	Type:____________________
Date:__________	Type:____________________
Date:__________	Type:____________________

MEDICAL HISTORY

Do you have, or have you had any of the following:

☐ Yes ☐ No Heart Problems
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Rheumatoid Arthritis
☐ Yes ☐ No Mental Health Condition
☐ Yes ☐ No Women: Are you pregnant or think you may become pregnant?
☐ Yes ☐ No Depression
☐ Yes ☐ No Epilepsy/Seizures
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Polio
☐ Yes ☐ No Dizziness
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Allergies
☐ Yes ☐ No Other

Details/Other:____________________

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SPECIAL SCREENING QUESTIONS FOR ELBOW, WRIST, AND HAND PAIN

☐ Yes ☐ No Have you recently had a trauma, such as a fall onto your hands?
☐ Yes ☐ No Have you recently had a surgery for your neck, shoulder, or arm?
☐ Yes ☐ No Do you have numbness or tingling in your hands?
☐ Yes ☐ No Has a doctor ever told you that you have osteoporosis (brittle bones)?
☐ Yes ☐ No Have you recently had a sore, cut, scrape, wound, or human/animal bite?
☐ Yes ☐ No Have you recently had an infection?
☐ Yes ☐ No Have you recently or do you now have a fever?
☐ Yes ☐ No Have you noticed an inability to move your wrist or elbow normally?
☐ Yes ☐ No Do your hands or feet easily turn white or become painful when cold?
☐ Yes ☐ No Have you noticed any newly formed or irregular moles on your body?
☐ Yes ☐ No When you have pain, does it respond to pain medication?

CURRENT MEDICATIONS

Please list:____________________

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PLEASE PRINT YOUR NAME BELOW

Printed Name:____________________Date:__________