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UPPER/LOWER EXTREMITY HISTORY

Name: _____ Age: _____

Referring MD: _____ Primary MD: _____

Why are you seeing Dr. Kefalas?

_____

Did you sustain an injury? _____ When did it happen/onset? _____

Where did it happen?

_____

Have you been seen by any other orthopedic M.D? _____ Whom? _____

When? _____ What was the treatment? _____

Did you require surgery? _____

Have you had any previous X-ray, PT, MRI, EMG, CT, injections, medications, or treatment for the problem? Describe: _____

Who was the doctor ordering these tests? _____

Where were these test/treatments performed? _____

Do you experience numbness/tingling? _____ if yes, please describe: _____

_____

What causes pain? _____

What gives relief? _____

Do you wake with this pain? _____

Have you had any previous difficulty or injury to this extremity? _____

Do you have arthritis? _____

Are you claiming this work related? _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____