

Orthopaedics and Rehabilitation Excellence of Miami
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Upper Extremity Symptom and Pain Questionnaire

Last Name _____ First Name _____ MI _____

Age _____ Occupation _____

Which Extremity?: () Right () Left () Both

Which part of upper extremity?: () Shoulder () Arm () Elbow () Wrist () Hand () Fingers

Type of Injury?: () Sports Injury () Work Injury () Motor Vehicle Accident () Other, Describe _____

Approximate Date of Onset of Pain: _____

Describe how you injured your upper extremity: _____

Rate your pain/discomfort (circle one): None 1 2 3 4 5 6 7 8 9 10 Severe

Major Complaint: () Pain () Loss of Motion () Night Pain () Buckling () Instability () Grinding () Other _____

Pain is: () Constant () Frequent () Occasional () Sharp () Throbbing () Burning () Electrical Shock () Nothing

Location of pain: () Front () Back () Side () Chest () Radiates Up Into Neck () Down Arm Into Hand () Other _____

Pain associated with: () Rest () Reaching () Sleeping () Throwing () Overhead Activities () Other, describe _____

Pain relieved by: () Rest () Activity () Heat () Ice () Medication, if so list _____

Are you experiencing numbness in the arm?: () No () Yes If yes, location _____

Can you dislocate your shoulder on your own?: () No () Yes

How many times has your shoulder dislocated?: _____ When was the last time your shoulder dislocated _____

Do you participate in sports? If so which: _____

Is your injury interfering with sports and/or activities of daily living: () No () Yes

Treatment to date (check all that apply):

- () None
- () Medicine, list _____ with what results: () Better () Worse () Same
- () Cortisone injection, when _____ By who? _____ with what results: () Better () Worse () Same
- () MRI/x-ray, when _____ who ordered it _____
- () Physical therapy, if so how long _____ with what results: () Better () Worse () Same
- () Surgery, procedure _____ Surgeon _____ date _____
- () Other, describe _____

Patient Signature: _____ Date ____/____/____

Reviewed By: _____ MD/PA/MA Date ____/____/____