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 Newton, MA 02462  
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 (617) 332-5150 (Hand Surgery)

40 and 54 Washington St.  
 Wellesley, MA 02481

**Newton Wellesley Orthopedic Associates Medical History Form**  
**New Patients or Current Patients with New Problem**

● **Patient Information**

Name: \_\_\_\_\_ Preferred name (if different): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Who is your primary physician? : \_\_\_\_\_ Who referred you to us? \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Dominant hand:  R  L

Occupation: \_\_\_\_\_

● **Reason for Visit:** \_\_\_\_\_

Were you seen in the E.R. or Urgent Care for this problem?  N  Y, location: \_\_\_\_\_ date: \_\_\_\_\_

Have you had any x-rays or other tests for this problem?  N  Y, what test: \_\_\_\_\_ location: \_\_\_\_\_

● **Current Medications:**  check if not currently taking any medications

Please list: \_\_\_\_\_

\_\_\_\_\_

● **Allergies:**  check if none \_\_\_\_\_

Do you use tobacco?  Y  N If Yes, packs per day: \_\_\_\_\_

Do you drink alcohol?  Y  N If yes, how often? \_\_\_\_\_

● **Past Surgical History:**  check if none \_\_\_\_\_

\_\_\_\_\_

● **Past Medical History:**

Are you Diabetic?  Y  N If Yes, treatment:  Insulin  Oral Meds  Diet  None

Do you have a history of a blood clot?  Y  N If yes, please describe the circumstances: \_\_\_\_\_

Are you taking, or have you ever taken, blood thinners?  Y  N If yes, which one: \_\_\_\_\_

Have you ever had (check all that apply):  Heart attack (year \_\_\_\_\_)  Stroke (year \_\_\_\_\_)  Heart Failure

High Blood Pressure  Ankle Swelling  Gout  Cancer (location) \_\_\_\_\_

Stomach ulcer / gastritis taking anti-inflammatory medication (caused by  Advil  Aleve  Other \_\_\_\_\_)

Other medical conditions: \_\_\_\_\_

**Please complete other side of this Medical History form**

• **Description of Problem**

<b>In this section, check the <u>ONE BOX</u> which best describes how your problem started. Then answer the question/provide the information requested below the box you checked using the space to the right.</b>	
<input type="checkbox"/> <b>NO INJURY:</b> <input type="checkbox"/> Gradual onset   or <input type="checkbox"/> Sudden onset  <input type="checkbox"/> <b>INJURY:</b> <input type="checkbox"/> Accident <input type="checkbox"/> Sport <b>Date:</b> _____  <input type="checkbox"/> <b>INJURY AT WORK:</b> <b>Date:</b> _____  <input type="checkbox"/> <b>AUTO ACCIDENT:</b> <b>Date:</b> _____	<b>PLEASE DESCRIBE PROBLEM BRIEFLY:</b> <hr/> <hr/> <hr/>

How long ago did it start? \_\_\_ Days \_\_\_ Weeks \_\_\_ Months \_\_\_ Years. **Have you had a problem like this before?**    Y    N

On a scale of 0 – 10 (10 is the worst) how **severe** is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the **quality** of the pain?    Sharp    Dull    Stabbing    Throbbing    Aching    Burning    None

The pain is:    Constant    Comes and goes (intermittent)    Absent

Do you have:    Swelling    Bruises    Numbness    Tingling    Weakness    Locking/Catching    Giving way

Since my problem started, it is:    Getting better    Getting worse    Unchanged

What makes your symptoms **worse**?    Standing    Walking    Lifting    Exercise    Twisting    Lying in bed

Bending    Squatting    Kneeling    Stairs    Sitting    Coughing    Sneezing    Other: \_\_\_\_\_

Which make your symptoms **better**?    Rest    Elevation    Ice    Heat    Other: \_\_\_\_\_

• **Treatments for Problem**

Have you had any of these treatments?    Medication    Injection    Brace    Cane/Crutch    Physical Therapy

Describe any other treatments for this problem: \_\_\_\_\_

Have you ever had surgery for a problem in this **same area**?    Y    N

Procedure: \_\_\_\_\_ Surgeon: \_\_\_\_\_ Date: \_\_\_\_\_

• **Review of Systems**

Have you had any of the symptoms **LISTED BELOW**? If no, please mark **None**.

System			Year	None
<b>Gastrointestinal</b>	<input type="checkbox"/> Heartburn/Ulcers	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/>
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver Disease		
<b>Endocrine</b>	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Heat/Cold Intolerance		<input type="checkbox"/>
<b>Constitutional</b>	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Fevers/Chills/Night Sweats	<input type="checkbox"/>
<b>Eyes</b>	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Vision Loss	<input type="checkbox"/>
<b>Ear/Nose/Throat</b>	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/>
<b>Cardiovascular</b>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations		<input type="checkbox"/>
<b>Respiratory</b>	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Shortness of Breath		<input type="checkbox"/>
<b>Urinary</b>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/>
<b>Skin</b>	<input type="checkbox"/> Frequent Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Psoriasis	<input type="checkbox"/>
<b>Neurology</b>	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seizures	<input type="checkbox"/>
<b>Psychological</b>	<input type="checkbox"/> Depression	<input type="checkbox"/> Drug/Alcohol Addiction	<input type="checkbox"/> Sleep Disorder	<input type="checkbox"/>
<b>Hematology</b>	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Anemia	<input type="checkbox"/>

**PLEASE SIGN:** The information on this form is accurate to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ MD/PA Signature \_\_\_\_\_