

**Newton Wellesley Orthopedic Associates Medical History Form**  
 New Hand Patients or Current Hand Patients with New Problem rev. 11.15.2011

**Patient Information**

Patient Name: \_\_\_\_\_ Preferred name (if different) \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  F  M Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Dominant hand:  R  L

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

Occupation: \_\_\_\_\_ Work Status:  Employed  Unemployed  Disabled

**Reason for Visit**

Shoulder L R	Elbow L R	Wrist L R	Hand L R	Thumb L R	Index Finger L R	Long Finger L R	Ring Finger L R	Small Finger L R
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Pain  Numbness  Weakness  Swelling  Stiffness  Other: \_\_\_\_\_

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

**Description of Problem**

In this section, check the ONE BOX 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.

- NO INJURY:**  Gradual onset  Sudden onset
- INJURY:**  Accident  Sport **Date:** \_\_\_\_\_
- INJURY AT WORK:** **Date:** \_\_\_\_\_
- AUTO ACCIDENT:** **Date:** \_\_\_\_\_

**PLEASE DESCRIBE PROBLEM BRIEFLY:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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?  Lifting  Exercise  Twisting  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  Physical Therapy  Cane/Crutch

Were you seen in the E.R. for this problem?  Y  N Where? \_\_\_\_\_ Date: \_\_\_\_\_

What test/scans have you had for this problem?  X-Rays  MRI  CAT Scan  Bone Scan  Nerve Test

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

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

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

## Review of Systems

Do your **other joints** have:  Morning stiffness lasting over 30 minutes  Joint pain or swelling  Back Pain  Gout  
 Rheumatoid arthritis  Osteoporosis  Prior fracture (which bone) \_\_\_\_\_  None of these

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

System				Year	None
<b>Gastrointestinal</b>	<input type="checkbox"/> Heartburn/Ulcers <input type="checkbox"/> Hepatitis	<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Liver Disease	<input type="checkbox"/> Blood in Stool		<input type="checkbox"/>
<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"/>
<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"/>

## Past Medical History

List current medical problems: \_\_\_\_\_

List current medications and dosage: \_\_\_\_\_

ALLERGIES (medication, latex, or food): \_\_\_\_\_

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

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

Past Surgical History or hospitalizations: \_\_\_\_\_

Have you or a family member ever had a reaction to anesthesia?  Y  N Explain: \_\_\_\_\_

Have you ever had (check all that apply or none if none apply):  Heart attack (year \_\_\_\_\_)  Blood Clots (year \_\_\_\_\_)

Stroke (year \_\_\_\_\_)  Heart Failure  High Blood Pressure  Ankle Swelling  Kidney Failure

Stomach ache while taking anti-inflammatory medication (caused by  Advil  Aleve  Other \_\_\_\_\_)

Cancer (location) \_\_\_\_\_  None apply

## Family and Social History

Have any **direct** relatives had any of the following disorders? If so, which relative?  Diabetes \_\_\_\_\_

High Blood Pressure \_\_\_\_\_  Rheumatoid Arthritis \_\_\_\_\_

Do you use tobacco?  Y  N If Yes, packs per day \_\_\_\_\_ Alcohol use?  Y  N If yes, how often? \_\_\_\_\_

Marital History:  M  S  D  W How many people live with you? \_\_\_\_\_

Do you use a crutch or cane?  Y  N Which hand?  Left  Right

Exercise/Sports Activities: \_\_\_\_\_

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

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