

Newton Wellesley Orthopedic Associates Medical History Form

New Patients or Current 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	Hip L R	Knee L R	Ankle L R	Foot L R	Neck	Back
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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 or 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**? 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 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
Gastrointestinal	<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			
Endocrine	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Heat/Cold Intolerance			<input type="checkbox"/>
Constitutional	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Loss of Appetite			<input type="checkbox"/>
Eyes	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Vision Loss		<input type="checkbox"/>
Ear/Nose/Throat	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Trouble Swallowing		<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations			<input type="checkbox"/>
Respiratory	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Shortness of Breath			<input type="checkbox"/>
Urinary	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Kidney Problems		<input type="checkbox"/>
Skin	<input type="checkbox"/> Frequent Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Psoriasis		<input type="checkbox"/>
Neurology	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seizures		<input type="checkbox"/>
Psychological	<input type="checkbox"/> Depression	<input type="checkbox"/> Drug/Alcohol Addiction	<input type="checkbox"/> Sleep Disorder		<input type="checkbox"/>
Hematology	<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? _____

Exercise/Sports Activities: _____

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

Patient Signature _____ Date _____ MD/PA Signature _____