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

□ **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 <u>other joints</u> 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 **<u>LISTED BELOW</u>**? If no mark **None**.

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

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 <u>or</u> 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 <u>direct</u> 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_____