MR#:______________

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(617) 332-5150 (Hand Surgery)

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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:_______ **Sex: :** ☐ M ☐ F **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

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	**PLEASE DESCRIBE PROBLEM BRIEFLY:** ______________________
☐ **INJURY**: ☐ Accident ☐ Sport **Date:**___________	______________________
☐ **INJURY AT WORK: Date:**___________	______________________
☐ **AUTO ACCIDENT: Date:**___________	

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**
Gastrointestinal	☐Heartburn/Ulcers ☐Hepatitis	☐Nausea/Vomiting ☐Liver Disease	☐Blood in Stool		☐
Endocrine	☐Thyroid Disease	☐Heat/Cold Intolerance			☐
Constitutional	☐Weight Loss	☐Loss of Appetite	☐Fevers/Chills/Night Sweats		☐
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		☐

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

Patient Signature_______________________________Date__________________MD/PA Signature______________________