The GW Medical Faculty Associates | Department of Orthopaedic Surgery

New Patient Form

Name: ____________________________ **Date of Birth:** ___________________ **Today's Date:** ______________________

Who referred you to our office? *Name/Address/Phone Number/Specialty* **Age:** _________ ☐ **Male** ☐ **Female**

____ **Height:** _______ **Weight:** __________

Primary Care Physician name and contact information *(if different than referring doctor)*

____

Is the problem you are being seen for today:
Work related injury? ☐ Yes ☐ No
Automobile accident? ☐ Yes ☐ No
Personal injury/lawsuit: ☐ Being considered ☐ Ongoing/active

Side of the pain or problem: ☐ Right ☐ Left ☐ Both Sides

Which hand do you write with? ☐ Right ☐ Left ☐ Both Hands

Please describe your current orthopaedic problem/injury (how it started, symptoms, etc.):

____

____

On what date did the problem start? ____________________ **How did it start?** ☐ Suddenly ☐ Gradually

Mark the number/spot that best represents your average pain level over the last week:

(No pain**)** **0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10** (Worst Pain Imaginable)

Mark the number/spot that best represents your overall disability/dysfunction level:

(Normal Function) **0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10** (Wheelchair/Bedbound)

Pain Quality: ☐ sharp ☐ dull ☐ stabbing ☐ stinging ☐ aching
☐ throbbing ☐ burning ☐ tingling ☐ electrical

Associated Symptoms: ☐ swelling ☐ redness ☐ warmth ☐ stiffness ☐ locking/catching ☐ numbness
☐ deformity ☐ lump/mass ☐ cut/laceration ☐ open sore/ulcer ☐ instability/giving way

Timing of Pain: ☐ morning ☐ night ☐ constant ☐ variable ☐ wakes you up from sleep
☐ gets worse as the day goes on ☐ gets worse with exercise ☐ gets *worse* with activity/movement
☐ start-up pain (worse with first few steps after sitting/resting) ☐ gets *better* with activity/movement

Does the pain radiate? ☐ Yes ☐ No If yes, from where to where? _______________________________________

What makes the symptoms better? ____

What makes the symptoms worse? ____

Have you ever had a similar pain/problem in the past? ☐ Yes ☐ No When? ______________________________

Treatments tried so far: ☐ Rest ☐ Ice ☐ Heat ☐ Cane/crutches/walker ☐ Orthotics/shoe inserts/pads

☐ Boot *(#wks)* _________ ☐ Brace *(#wks, what type?)* _________________________ ☐ Cast/splint *(#wks)* _________

☐ Physical/Occupational Therapy *(#wks)* ______ ☐ Other treatments ____________________________________

☐ Medication for this problem *(name/dose/duration)* ____

☐ Injections *(how many? % improvement, duration?)* ____

Prior surgery for this problem or body part *(who/where/when/what)* ______________________________________

Prior tests/imaging: ☐ X-Ray ☐ MRI ☐ CT ☐ Bone Scan ☐ Ultrasound ☐ Nerve Testing ☐ Blood Tests

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Name: ______________________________

Past Medical History: *Please list any other medical conditions you have*

☐ High Blood Pressure	☐ Heart Failure	☐ Heart Attack	☐ Pacemaker	☐ Atrial Fibrillation
☐ Vascular Disease	☐ Asthma	☐ Emphysema/COPD	☐ Sleep Apnea	☐ Pulmonary Embolism
☐ Blood Clots	☐ Diabetes	☐ Thyroid Problems	☐ Kidney Problems	☐ Dialysis
☐ Cirrhosis	☐ Hepatitis (☐ *A* ☐ *B*	☐ *C*)	☐ Stomach Ulcer	☐ Reflux/GERD
☐ Colitis/Crohn's	☐ Seizure Disorder	☐ Stroke/TIA	☐ Neuropathy	☐ Charcot-Marie-Tooth
☐ Parkinson's Disease	☐ Polio	☐ Osteoporosis	☐ Osteoarthritis	☐ Rheumatoid (RA)
☐ Lupus/SLE	☐ Psoriasis	☐ Gout	☐ Fibromyalgia	☐ Lyme Disease
☐ HIV/AIDS	☐ Tuberculosis	☐ Anemia	☐ Depression	☐ Anxiety

☐ Cancer [Type: ___________________________] ☐ Other: ____

Past Surgical History: List *all* surgeries you have ever had *(example: appendix, tonsils, gallbladder, hysterectomy, etc.)*

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Have you had any problems with anesthesia? *(describe)* ____

Family History: *Please list any medical conditions that run in your family*

☐ Diabetes	☐ Heart Disease	☐ Blood Clots	☐ Anesthesia Problems	☐ Cancer
☐ High Blood Pressure	☐ Charcot-Marie-Tooth	☐ Other: ____________		

Social & Personal History:

Occupation: __________________________________ ☐ Student ☐ Homemaker ☐ Retired ☐ Unemployed ☐ Disabled

Do you get to exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily What type of exercise: ______________________________

Number of stairs at home: _________ **Who Do You Live With?** ____

Hobbies/Interests: ____

Do you smoke (cigarettes, cigars, e-cigarettes, vaping)? ☐ Yes ☐ No ☐ Quit (when?) _________________________

The most you have ever smoked on a regular basis? _____________ How many years have you/did you smoke in your life? _____________

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit (when?) _______________ Drink of choice? # per week? _____________________

Recreational drugs? ☐ Currently use ☐ Used in the past ☐ Never used What type? ___________________________________

Review of Systems: *Please list any other symptoms that you **currently** have*

Hematologic
- ☐ Bleeding Tendency
- ☐ Easy Bruising

Constitutional
- ☐ Fevers ☐ Chills
- ☐ Night Sweats
- ☐ Unplanned Weight Gain
- ☐ Unplanned Weight Loss

Genitourinary
- ☐ Incontinence
- ☐ Problems Urinating
- ☐ Burning with Urination

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Heart Murmur
- ☐ Swelling in the Legs

Gastrointestinal
- ☐ Nausea ☐ Vomiting
- ☐ Constipation
- ☐ Chronic Diarrhea
- ☐ Blood in Stool

Psychiatric
- ☐ Anxious ☐ Depressed/Sad

Neurologic
- ☐ Numbness ☐ Tingling
- ☐ Weakness
- ☐ Dizziness
- ☐ Balance Problems
- ☐ Frequent Headaches

Skin
- ☐ Rash ☐ Itching
- ☐ Non-healing Sores

Head/Ears/Nose/Throat
- ☐ Hearing Loss
- ☐ Tooth Pain ☐ Gum Bleeding

Pulmonary
- ☐ Chronic Cough
- ☐ Wheezing
- ☐ Shortness of Breath

Musculoskeletal
- ☐ Stiffness ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck ☐ Back Problems

Eyes
- ☐ Double Vision
- ☐ Blurry Vision
- ☐ Blindness/Vision Loss

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Name: ______________________________

Allergies: ☐ **No Allergies** ☐ Penicillin ☐ Latex ☐ Iodine ☐ Shellfish ☐ Adhesives

Please list anything else you are allergic to, including what reactions you have had *(examples: hives, trouble breathing, etc.)*

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____

Medications: ☐ **No Medications**

Please list all medications/vitamins/supplements below, or attach a list

____

____

____

Preferred Pharmacy: ____

Spine Pain Questionnaire (For Spine Patients):

Please draw in wherever you are feeling any of the following symptoms, using the following symbols:

Pain (+)

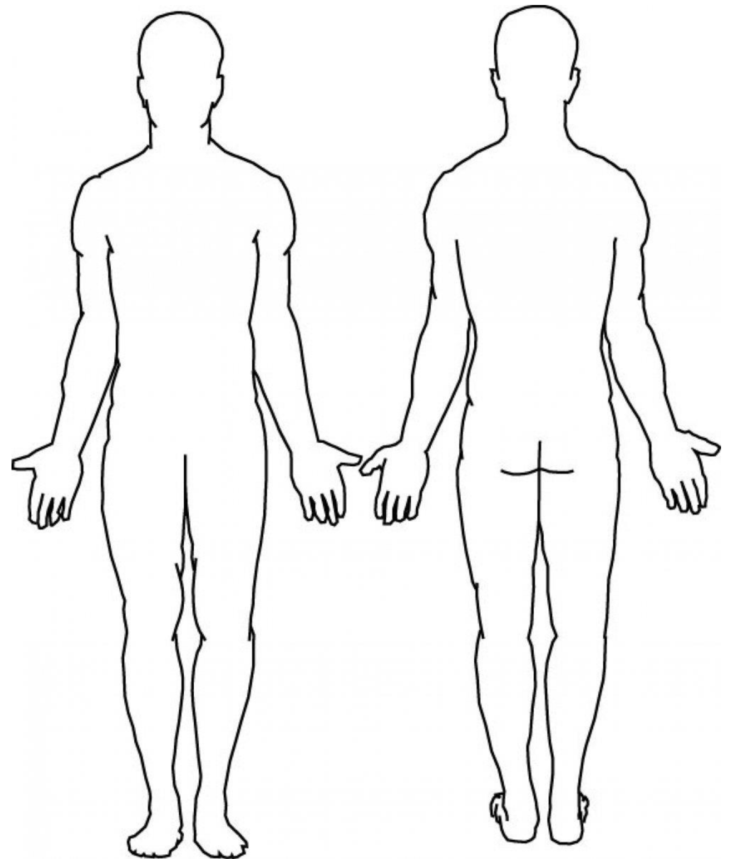
Numbness (-)

Tingling (O)

Burning (X)

What percentage of your pain is in these areas:

Back	%
Buttock/leg	%
Neck	%
Shoulder/arm	%



I have reviewed the above information, and attest that it is true and correct to the best of my knowledge.

Patient's Signature: ______________________ *Physician/NP's Signature:* ______________________