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)*

_____

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

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

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

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 <u>average</u> pain level over the <u>last week</u>:

(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 ☐ bruising ☐ 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 <u>this</u> problem or body part *(who/where/when/what)* _____

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

<u>Continues on the Back: Please Complete All Pages</u>

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.)*

_____

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.)*

_____

_____

Medications: ☐ **No Medications**

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

_____

_____

_____

Preferred Pharmacy: _____

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:* _____