ORTHOPAEDIC SURGERY
at The GW Medical Faculty Associates

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202.741.3311

Welcome to Orthopaedics!

In an effort to make your visit with us at the Department of Orthopaedic Surgery as efficient as possible, please be sure to bring the following to your upcoming appointment:

- Completed patient history forms (attached)
- Government Issued Photo ID
- Current Insurance Card
- Referral (check with your insurance company to see if one is required for a specialty appointment)
- Any reports from prior surgery
- Any reports and images from prior imaging studies (X-rays, MRI, CT scans, etc.)

We look forward to seeing you at your upcoming appointment!

If you have any questions, please feel free to contact our office at 202.741.3305.

Sincerely,

The Department of Orthopaedic Surgery

New Patient History

Name:_______________________________________ Age:______ Date: ________________

Height: ___________ Weight:___________

Name and Address the doctor who referred you here :

____

____

_ ____

Side of pain/problem: Right Left **Handed:** Right Left

Date of injury: ______________________________

Main problem (describe any injury/accident and location of pain or problem):

____

_ ____

Pain level/character (please check all that apply):

☐ None	☐ Electrical	☐ Occasional pain	☐ Pain improving
☐ Mild	☐ Dull	☐ Constant pain	☐ Pain worsening
☐ Moderate	☐ Sharp	☐ Pain with activities	☐ No change
☐ Severe	☐ Burning	☐ Night pain	

Pain worsens with: ____

Pain improves with:____

List current medications you take *for your pain*: ____

Have you seen any other doctors for your problem? ☐ yes ☐ no

Have you had any studies for this condition (Xrays, Nerve studies, MRI…)?_________________________

Have you had or tried any of the following treatments for this problem (check all that apply)?:

☐ Physical therapy	☐ Injections	☐ Surgery
☐ Bracing or splints	☐ Ice or heat	☐ NSAIDS (ie, Ibuprofen, Aleve or Motrin)

What is your occupation? _______________________ Was there a work related injury? ☐ yes ☐ no

Are you currently working? ☐ yes ☐ no If no, when did you last attend work? ______________

Do you have or have you ever had any of the following medical problems?

Diabetes	High Blood Pressure	Heart Disease	Pacemaker
DVT/PE/Blood Clot	Kidney Disease	Cancer	Thyroid Disease
Ulcers	Stroke	Frequent Infections	HIV/AIDS
Epilepsy	Asthma	Arthritis	COPD
Depression	Hepatitis		

If you listed yes to any of the above, or have any other health conditions please explain below.

List past surgeries and dates

List all medications you take including vitamins and supplements

List any allergies you have:____

Smoking: ☐ none ☐ Less than ½ pk/day ☐ ½ pk/day ☐ 1 pk/day ☐ 2 pk/day
☐ Quit, last smoked ____

Alcohol: ☐ never ☐ 1 day/month ☐ 1-3 days/wk ☐ 3-5 days/wk ☐ every day

Activities and Hobbies?

Family History: What problems run in your family? (diabetes, high blood pressure, cancer, heart disease)

Do you have any of the following (check all that apply)?

General
☐Weight loss
☐Weight gain
☐Decreased Appetite
☐Fevers
☐Chills
☐Night sweats

Skin
☐Rashes
☐Itching
☐Skin color changes
☐Dermatitis

HEENT
☐Headaches
☐Blurred vision
☐Ringing in ears
☐Bloody Noses
☐Sore throat
☐Thyroid problems
☐Pituitary problems

Respiratory
☐coughing
☐wheezing
☐Shortness of breath
☐Tuberculosis

Cardiovascular
☐Palpatations
☐Coronary Disease
☐Heart Attack
☐Stroke
☐Leg Swelling

GI
☐Nausea
☐Vomiting
☐Diarrhea
☐Incontinence
☐Constipation
☐Blood in stool
☐Dark tary stools
☐Jaundice
☐Diabetes
☐Liver problems

GU
☐Pain with urination
☐Blood in urine
☐Incontinence
☐Difficulty urinating

Neuro
☐Seizures
☐Dizziness
☐Balance problems

Hematologic
☐Easy bruising
☐Excessive bleeding
☐Anemia

Psychiatric
☐Depression
☐Bipolar
☐Paranoia
☐Schizophrenia

By signing below, I attest the above information is true and correct to the best of my knowledge:

____ Date ________________________