MedStar Orthopaedic Institute

MedStar Orthopaedic Institute
at St. Mary's Hospital
Leonardtown, MD

NEW PATIENT FORM

Please **completely** fill in the appropriate blanks and answer all questions. *All questions in this questionnaire are strictly confidential and will become part of your medical record.*

NAME:_____ **TODAY'S DATE**:_____

AGE:_____DATE OF BIRTH:_____HEIGHT:_____WEIGHT:_____

RIGHT or LEFT HANDED (circle) **PRIMARY CARE PROVIDER (PCP):**_____

OCCUPATION:_____JOB Duties:_____

Are you currently working?:_____YES _____NO

Is **Light Duty** available?: _____YES _____NO

PREFERRED PHARMACY:_____

HAVE YOU SEEN ANOTHER PHYSICIAN: ___YES___NO **If yes, provide name:**_____

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CHIEF COMPLAINT (please circle): RIGHT LEFT BOTH

REASON FOR VISIT: _____

WHEN DID YOUR SYMPTOMS BEGIN?_____

WAS THE INJURY WORK RELATED? _____YES _____NO

WAS THE INJURY RELATED TO A MOTOR VEHICLE ACCIDENT? _____YES_____NO

PLEASE DESCRIBE HOW THE SYMPTOMS OR INJURY OCCURRED:_____

_____

_____

PLEASE DESCRIBE YOUR CURRENT SYMPTOMS (Write Answer or Circle all that Apply):

Location of Pain or Complaint:

Which Joint or Extremity:_____

Location on Joint/Extremity: Inner Outer Front Back Middle Deep Top

Onset and Timing of Pain: Gradual Sudden Constant Intermittent

Type of Pain: Dull Sharp Throbbing Achy Stabbing Shooting Gradual onset Sudden onset

Pain Severity (1: mild to 10: most severe)**: 1 2 3 4 5 6 7 8 9 10**

Are Symptoms associated with any of the following:

Weakness Instability Swelling Locking Catching Clicking Buckling Squatting

Stiffness Night Pain Numbness Tingling Other_____ **NONE**

Is pain present/increased with: Rest Reaching (Out, Behind) Overhead Activity Throwing

Lifting Carrying Motion Sitting Rising from Chair Climbing Squatting Initial Steps

Walking (How Far?)_____Running (How Far?)_____**NONE of the above**

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Is pain improved with: Rest Ice Stretching PT/Exercise Walking Meds_____

Does your pain affect SLEEP: Awaken Increased Pain Other_____ **NONE**

WHICH OF THE FOLLOWING SYMPTOMS IS THE MOST BOTHERSOME:

(please circle one): Pain Weakness Stiffness Instability

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM (circle or write answer)

X-rays Ice Heat Activity Modification Off Work Other_____

Medication (name)_____currently taking med? ___ Yes ___ No

Injections (how many/date of most recent)_____

Physical Therapy/Chiropractic Therapy (date of last visit)_____

MRI (Location/Date)_____EMG (Location/Date)_____

Surgery (type/date):_____

Which of the above treatments has improved your symptoms:_____

ANY SPORTS/ACTIVITIES/HOBBIES?_____

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PAST MEDICAL HISTORY: (please circle yes or no)

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Heart Attack	Yes	No	Seizure	Yes	No	Pacemaker	Yes	No
Lung Disease	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	HIV/AIDS	Yes	No	Stomach Problems	Yes	No
Hepatitis	Yes	No	Blood Clots	Yes	No	High Cholesterol	Yes	No
Thyroid Issues	Yes	No	Psychiatric	Yes	No	Other:_____		

PAST SURGERIES and APPROXIMATE DATES:_____

_____

_____

DRUG ALLERGIES:_____LATEX ALLERGY: _____YES _____NO

CURRENT MEDICATIONS_____

_____

_____

FAMILY HISTORY: (Any medical problems in your blood relatives?)

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Mother:_____Father: _____

Siblings:_____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Currently ☐ Past **Quit Date**:_____ **#/Day**_____

☐Cigarettes ☐ Chewing ☐ Cigars ☐ Pipe ☐ Smokeless/e-cig

Alcohol Use: ☐ Never ☐ Social ☐ Daily ☐ **#/Day** _____

Drug Use: ☐ No ☐ Yes **Type and Frequency**_____

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REVIEW OF SYSTEMS

DO YOU HAVE TROUBLE WITH ANY OF THE FOLLOWING? (Circle all that apply)

Constitutional:

Fever / Chills

Night Sweats

Tired / Fatigue

HEENT:

Teeth Infections

Nasal Congestion

Sore throat / Swallowing

Eyesight / Hearing

Cardiovascular:

Chest Pain

Palpitations

Respiratory:

Shortness of Breath

Cough / Sputum

GI:

Nausea / Vomiting

Diarrhea / Constipation

Genitourinary:

Increased Urinary Frequency

Painful Urination

Musculoskeletal:

Joint pain or Joint Swelling

Leg or Soft Tissue Swelling

Muscle Aches

Skin:

Laceration / Abrasion of injured area

Rash / Itching

Neuro:

Numbness or Tingling

Headache

Recent Falls / Balance

Psych:

Memory change

Depression

Heme/lymph:

Easy Bruising or Bleeding

Blood Clots

Endocrine:

Increased need to drink Fluid such as Water

Increased Frequency of Urination

Weight Loss or Gain

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PATIENT SIGNATURE:_____ **DATE:**_____

Reviewed:_____

FOR OFFICE USE ONLY:

HT:_____ WT:_____ TEMP:_____ BP:_____ HR:_____