SUMMIT ORTHOPAEDIC SURGERY

NEW PATIENT MEDICAL HISTORY FORM

Philip D. Bobrow, M.D., F..A.C.S
Michael E. Goldsmith, M.D.
Steven H. Bernstein, M.D.
Mustafa A. Haque, M.D.
Gautam Siram, M.D.
Jatinder Narula, M.D.

Patient Name: _____ **DOB:** _____ **Gender:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Cell:** _____ **Work:** _____

Social Security Number: _____ **Family Doctor:** _____

Email: _____ **Emergency Contact:** _____ **Phone:** _____

Pharmacy: _____ **Address:** _____ **Phone:** _____

Employer: _____ **Address:** _____ **Phone:** _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Chief Complaint

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness Other: _____

Shoulder	○ Right	○ Left	Pelvis	○ Right	○ Left	Neck	○
Upper Arm	○ Right	○ Left	Hip	○ Right	○ Left	Mid Back	○
Elbow	○ Right	○ Left	Thigh	○ Right	○ Left	Low Back	○
Forearm	○ Right	○ Left	Knee	○ Right	○ Left	Buttocks	○
Wrist	○ Right	○ Left	Lower Leg	○ Right	○ Left	Tail Bone	○
Hand	○ Right	○ Left	Ankle	○ Right	○ Left		
Thumb	○ Right	○ Left	Foot	○ Right	○ Left		
Index	○ Right	○ Left	Toes	○ Right	○ Left		
Middle	○ Right	○ Left					
Ring	○ Right	○ Left					
Little	○ Right	○ Left					

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Describe how the symptoms started: _____

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

Approximate date of onset: _____

2. Have you had a problem like this before? ○ Yes ○ No

Describe: _____

_____

3. Have you been seen in an ER? ○ Yes ○ No

Treating ER: (ex. St. Luke's Health) _____ **Date:** (mm/dd/yyyy) _____

 Patient Name: _____

History of Present Illness (continued)

4. Rate the pain (10 being the most pain):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

5. Do the symptoms wake you from sleep?

○ Yes ○ No

6. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

7. What makes the symptoms worse?

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching Overhead

8. Are there any other symptoms associated with this problem?

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

9. Have you had any prior tests? ○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan

10. Have you had any prior treatment for this problem? ○ Yes ○ No

If yes, please select the type of treatment:

○ Rest ○ Anti-Inflammatory ○ Pain Meds ○ Chiropractor ○ Physical Therapy ○ Home Exercise Program
○ Surgery ○ Injections ○ Bracing

Select all previous hospitalizations/surgeries: ○ **None**

○ Aneurysm (Brain) Surgery	○ Hernia Repair
○ Aortic Bypass / Vascular Surgery	○ Hysterectomy
○ Appendectomy	○ LAP Band / Gastric Bypass Surgery
○ Back Surgery	○ Lumpectomy
○ Bowel Surgery	○ Mastectomy
○ Cataract (Eye) Surgery	○ Malignancy/Cancer
○ Cholecystectomy (Gallbladder)	○ Neck Surgery
○ Heart Surgery	○ Stents

Orthopedic on side:	Right	Left
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
Total Shoulder Replacement	○	○
Spinal Surgery - Indicate Level: _____		

Other Surgery

_____
_____
_____

Other Orthopedic Surgery

_____
_____
_____

 Patient Name: _____

Do you have any allergies? ○ No ○ Yes If Yes, please list below:

○ Aspirin	○ Anesthesia	○ Penicillin
○ Ibuprofen	○ Codeine	○ Sulfa
○ Adhesive Tape	○ Iodine dyes	○ Metals _____
○ Environmental	○ Latex	
○ Other: _____		

Please list all medications you take on a regular basis: ○ **None**

Medication	**Dosage and Frequency (e.g. 20 mg, once/day)**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a personal history of any of the following? ○ **None**

○ Aneurysm Where: _____	○ Emphysema	○ Kidney Disease
○ Angina (Chest Pain)	○ Epilepsy	○ Kidney Stones
○ Arthritis Type: _____	○ Heart Attack	○ MRSA Infection
○ Asthma	○ Hepatitis Type: _____	○ Pacemaker
○ Bone or Joint Infections	○ HIV / AIDS	○ Phlebitis (Blood Clots)
○ Cancer Type: _____	○ High Cholesterol	○ Pulmonary Embolism
○ Chemotherapy / Radiation	○ Hypertension	○ Reaction to Anesthesia Type: _____
○ COPD	○ Hyperthyroidism	○ Seizures
○ Congestive Heart Failure	○ Hypothyroidism	○ Stomach Ulcers
○ Diabetes Type: _____ Last A1C: _____		○ Stroke / TIA
		○ Tuberculosis

Please list any other medical conditions or details of medical conditions marked above:

_____

Height: _____ **Weight:** _____

Race: ○ Caucasian ○ African American ○ Hispanic ○ Asian ○ Other _____

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Other _____

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other _____

Do you smoke tobacco? ○ Current, every day smoker ○ Current, some day smoker ○ Former smoker ○ Never Smoker
○ Heavy tobacco smoker ○ Light tobacco smoker ○ Smoker, Current Status Unknown

Has the patient been seen as a new patient within the last 90 days? ○ No ○ Yes

 Patient Name: _____

Medical Questions

Mark all that currently apply:

○ Metal in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you taking blood thinners? ○ Yes ○ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

○ **None for all**

					None	Comments
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool		○	_____
2) ENDO	○ Fever	○ Heat or Cold Intolerance	○ Night Sweats		○	_____
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	_____
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	_____
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	_____
6) CV	○ Chest Pain	○ Palpitations			○	_____
7) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath		○	_____
8) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems		○	_____
9) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps	○ Psoriasis	○	_____
10) NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness		○	_____
	○ Change in Bowel	○ Change in Bladder	○ Dizziness			
11) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder		○	_____
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	_____

Family History

Have any direct relatives had any of the following disorders? ○ **None**

○ Diabetes ○ Heart Disease ○ Hypertension ○ Bleeding Problems ○ Epilepsy ○ Connective Tissue
○ Muscular Dystrophy ○ Stroke ○ Osteoporosis ○ Rheumatoid Arthritis ○ Cancer

Other: _____

Social History

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled ○ Student

If no, what date did you last work? _____

Please list work restrictions, if any: _____

_____ _____

Signature **Date**