

HAMPSHIRE ORTHOPEDICS & SPORTS MEDICINE, INC.

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NEW PATIENT MEDICAL HISTORY

Please do not leave any questions unanswered

Date: ____ - ____ - ____

Name: _____ DOB: ____ - ____ - ____ Age ____ Ht. ____ Wt. ____

Referred by a physician? ___ Yes ___ No Name: _____

Primary care physician if different from above. Name _____

1. **REASON FOR VISIT:** _____ **Side of Injury or pain?** _____

2. **WHEN** did your problem begin? _____

3. **HOW** did your problem begin? _____

4. **Is your injury work related?** _____

5. **If so, Name of your employer** _____

6. What are the symptoms? _____

7. What makes the problem **worse?** _____ **Better?** _____

8. Have you had any diagnostic tests for this problem? (Please **check** all that apply)

- X-rays
- Arthrogram (Dye injection)
- Electromyogram (EMG)
- MRI
- Injections (Cortisone)
- Nerve Conduction Study (NCS)
- CT Scan

Dates: _____ Place: _____ Have they been delivered here? Yes No Do you have them? Yes No

9. Were you seen in the **Emergency Room for this problem?** Yes **Date** _____ No

10. Have you seen another **Orthopedist** for this problem? _____

11. What treatment have you had for this problem? _____

12. **PAIN SCALE** (least) 1 2 3 4 5 6 7 8 9 10 (greatest)

13. Are you **RIGHT** or **LEFT** **Handed**

14. PAST MEDICAL HISTORY:

- Blood Clots (specify) _____ Stomach Ulcers/Reflux _____
- Asthma/Emphysema/COPD _____ Stroke _____
- High Blood Pressure _____ Kidney disease/failure(specify) _____ Diabetes _____
- Heart Problems: Heart Attack _____ Angina _____ Arrhythmia _____
- Easy Bleeding or Bruising _____ Contagious conditions: HIV _____ Hepatitis _____ TB/Other (specify) _____
- Cancer (*What type!*) _____ **Other:** _____

15. ALLERGIES: Do you have allergies to: Specify Allergy and Reaction (i.e. itching, rash, hives, difficulty breathing)

Drugs Yes No _____

Tape? Yes No Latex? Yes No Food? Yes No

16. MEDICATIONS: Do you take any medications? Please list *all* medications *and* their doses.

Medication	Dose/Freq.
_____	_____
_____	_____
_____	_____
_____	_____

17. FAMILY HISTORY: Does *anyone* in your family have a history of *any* medical problems? (Please **check** all that apply)

Arthritis	Blood Clots	Problems with Anesthesia	Spine problems
Cancer	Osteoporosis	Heart Disease	# of Siblings
Diabetes	Other _____		# of Children

18. SOCIAL HISTORY:

What is your occupation? _____ F.T. P.T. Retired
 Do you smoke? Yes No How much? _____ Did you smoke? Yes No Quit when? _____
 Do you drink alcohol? Yes No Rarely Socially Daily How many drinks per day? _____
 Have you ever had any addiction to drugs or medications? Yes No Which? _____
 Are you Married Single Committed Widowed Divorced/Separated Do you live alone? Yes No
 Do you exercise? Daily Weekly Monthly Rarely Never
 What type of exercise? _____

Education Completed Grade High School College Post Grad.

19. SYSTEM REVIEW: _____ **Excellent** _____ **Good** _____ **Fair** _____ **Poor?**

DO YOU HAVE PROBLEMS WITH THE FOLLOWING:

Constitutional fever weight loss tiredness	None
Eyes glasses blurred vision double vision	None
Ears/Nose/Throat deafness sinus infection ringing hoarseness dizziness difficulty swallowing	None
Heart chest pain irregular heart beat pounding in chest	None
Lungs shortness of breath wheezing cough cough up blood	None
Abdomen loss of appetite diarrhea constipation abdominal pain blood in stool black bowel movements	None
Urinary burning loss of urine difficulty voiding infections blood in urine	None
Menstrual regular irregular severe pain post-menopausal	None
Musculoskeletal sprains swelling arthritis stiffness	None
Skin/Breast rash skin ulcers sores lumps birthmarks masses	None
Neurologic balance problems memory problems	None
Behavioral depression anxiety sleep disturbance hallucinations claustrophobia	None
Endocrine hair growth/loss crave fluids/food hyperactive sleep all the time	None
Blood/Lymphatics easy bruising anemia enlarged glands	None
Immunologic Itching frequent colds/infections	None

NAME: _____

PAST SURGICAL HISTORY with dates:

FRACTURES / BROKEN BONES with dates:

****FOR OFFICE USE ONLY:**

Patient Exam:

- Pulse _____ Regular ___ Yes ___ No
- Height _____
- Weight _____
- BP: _____

Reviewed by: _____

ADDENDUM: