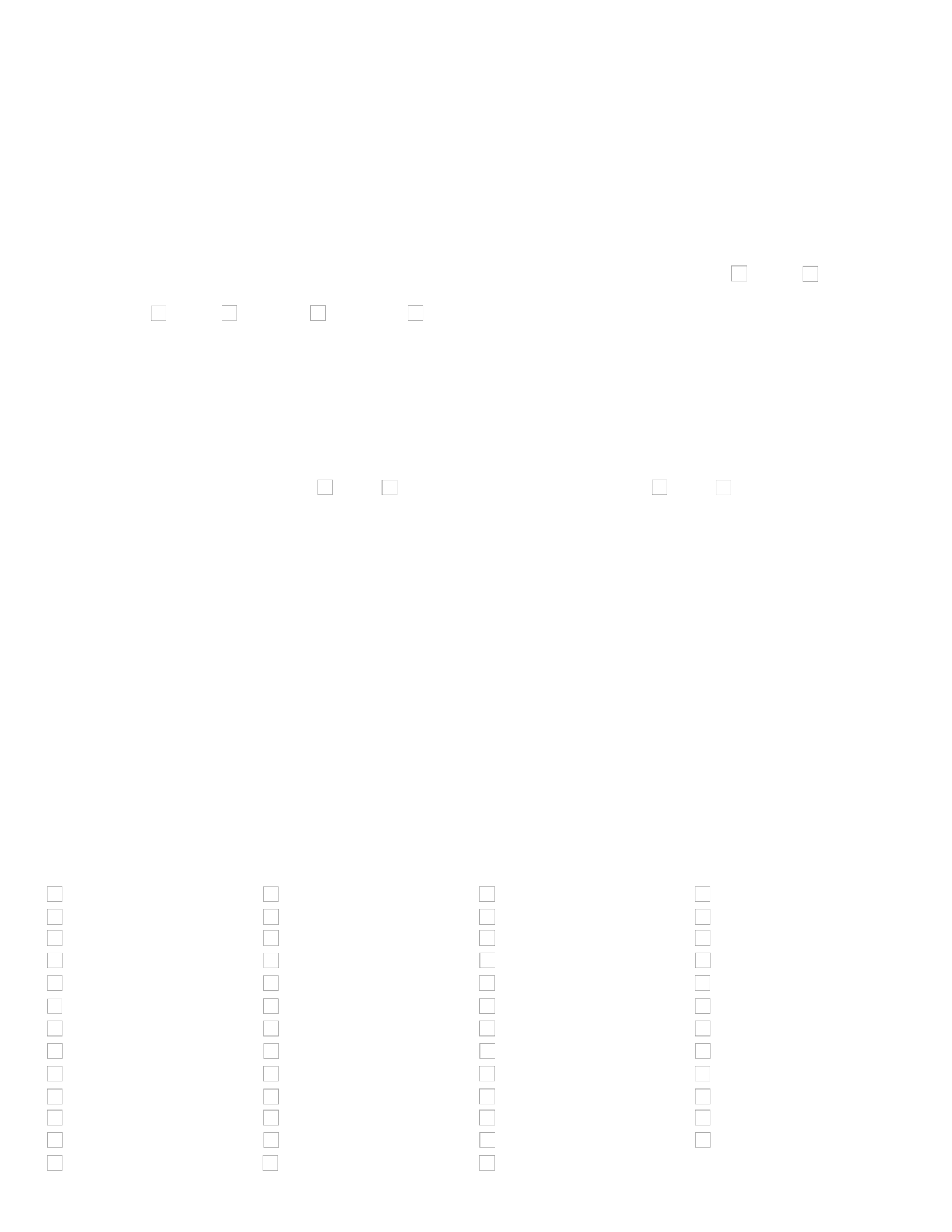

SEACOAST ORTHOPEDICS
21 Highland Avenue • Newburyport • MA • 01950
Telephone: (978) 462-7555 • Fax: (978) 462-0499

New Patient History Form (page 2 of 3)

Past Surgical History (please check all appropriate boxes)

- ☐ ACL surgery
- ☐ Angioplasty
- ☐ Heart stents
- ☐ Appendectomy
- ☐ Ankle arthroscopy
- ☐ Elbow arthroscopy
- ☐ Knee arthroscopy
- ☐ Hip arthroscopy
- ☐ Wrist arthroscopy
- ☐ Shoulder arthroscopy
- ☐ Back surgery
- ☐ Heart bypass surgery
- ☐ Heart valve surgery
- ☐ Carpal tunnel surgery
- ☐ Cataract surgery
- ☐ Gallbladder surgery
- ☐ Colon resection
- ☐ Colostomy
- ☐ Disk removal
- ☐ Gastric bypass
- ☐ Hernia repair
- ☐ Hip surgery
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ Laminectomy
- ☐ LASIK
- ☐ Meniscus surgery
- ☐ Muscle biopsy
- ☐ Broken bone fixation
- ☐ Pacemaker
- ☐ Rotator cuff surgery
- ☐ Bowel resection
- ☐ Thyroid surgery
- ☐ Tonsillectomy
- ☐ C-section
- ☐ Hysterectomy
- ☐ Breast surgery
- ☐ Prostate surgery

Other past surgical history: _____

Review of Systems (please check all appropriate boxes)

Constitutional: ☐ fever ☐ fatigue ☐ night sweats ☐ unintentional weight loss
HEENT: ☐ vision changes ☐ headaches ☐ hearing loss
Respiratory: ☐ cough ☐ wheezing ☐ shortness of breath
Cardiovascular: ☐ chest pain ☐ irregular heart beat
Gastrointestinal: ☐ vomiting ☐ diarrhea ☐ constipation ☐ abdominal pain
Genitourinary: ☐ pain with urination ☐ blood in the urine
Metabolic/Endocrine: ☐ frequent urination ☐ frequent thirst or hunger ☐ cold or heat intolerance
Neurologic/Psychiatric: ☐ dizziness ☐ emotional disturbances
Musculoskeletal: ☐ bone/joint pain ☐ bone/joint swelling ☐ weakness
Hematologic: ☐ bruising ☐ bleeding
Immunologic: ☐ food allergies ☐ seasonal allergies ☐ environmental allergies

Social History

Hand dominance: ☐ Left ☐ Right **Exercise level:** ☐ Sedentary ☐ Moderate ☐ Vigorous

Exercise frequency: ☐ Daily ☐ 3-5 times per week ☐ 1-2 times per week ☐ occasionally ☐ never

Do you smoke? ☐ Yes ☐ No **If yes, how many packs per day?** _____ **For how many years?** _____

How many drinks of alcohol do you consume in a typical week? _____

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New Patient History Form (page 3 of 3)

Family History

If one of your family members had or has any of the conditions listed below, please mark the appropriate boxes

- ☐ ADD/ADHD
- ☐ Alcoholism/Cirrhosis
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Asthma
- ☐ Blood/Bleeding problems
- ☐ Bone cancer
- ☐ Heart disease
- ☐ Cancer
- ☐ Colitis
- ☐ Heart failure
- ☐ Heart defects
- ☐ Emphysema
- ☐ Stroke
- ☐ Depression
- ☐ Developmental delay
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Mental delay
- ☐ Gout
- ☐ Hearing loss
- ☐ Hodgkin's disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental illness
- ☐ Migraines
- ☐ Muscle disease
- ☐ Obesity
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Vascular disease
- ☐ Seizure disorder
- ☐ Thyroid disease
- ☐ Anesthesia problems
- ☐ Osteoporosis

Your Current Problem

How long have you been having this problem? _____

How frequently does it occur? ☐ Persistently ☐ Intermittently ☐ Occasionally ☐ Rarely

How long does it last when it occurs? ☐ Less than 5 minutes ☐ 5-15 minutes ☐ 15-30 minutes ☐ 30-60 minutes ☐ Greater than 60 minutes ☐ Problem is always there

On a scale of 1 to 10, how severe is it? _____ **Does the pain travel?** ☐ Yes ☐ No

Where is the problem (please include which side of your body if applicable)? _____

How would you describe the pain? ☐ Aching ☐ Burning ☐ Dull ☐ Piercing ☐ Sharp ☐ Throbbing

Is your problem the result of any injury? ☐ Yes ☐ No **If yes, what was the date of the injury?** ____ / ____ / _____

If your problem is the results of any injury, how did the injury occur? _____

Is your problem made <u>worse</u> by any of the following? ☐ Bending ☐ Climbing stairs ☐ Descending stairs ☐ Lifting ☐ Movement ☐ Pushing ☐ Sitting ☐ Prolonged standing ☐ Walking Other _____

Is your problem made <u>better</u> by any of the following? ☐ Brace/splint ☐ Elevation ☐ Exercise ☐ Heat ☐ Ice ☐ An injection ☐ Massage ☐ Prescription meds ☐ Over the counter meds ☐ Movement/Walking ☐ Physical therapy ☐ Rest ☐ Stretching Other _____

Check all appropriate boxes if you are experiencing any of these symptoms as a result of your problem:

- ☐ Bruising
- ☐ Crunching noises
- ☐ Decreased motion
- ☐ Difficultly falling asleep
- ☐ Instability
- ☐ Limping
- ☐ Locking
- ☐ Night time awakening
- ☐ Numbness
- ☐ Popping
- ☐ Spasms
- ☐ Swelling
- ☐ Tingling in the arms
- ☐ Tingling in the legs
- ☐ Tenderness
- ☐ Weakness