Elliot Orthopedic Surgical Specialists

Today's Date:____/_____/_____

185 Queen City Ave., Manchester, NH 03101 phone (603) 625-1655

Name:_____Age:_____Birthdate:_____
Who sent you here today (yourself, ER/Urgent Care, primary physician)?_____
If you were referred by a health care provider, please specify their affiliation (Elliot, CMC, Dartmouth)

1) Why do you need an orthopaedic evaluation today?
_____

_____

2) Did you injure this area? Yes / No If Yes, date of injury: _____
Briefly describe injury: _____
Is this problem job related? Yes / No Automobile Accident? Yes / No
Was this area ever injured prior to this current problem? Yes / No
If no injury: How long has this area been problematic? _____
How did the problem occur (circle)? Suddenly / Gradually

3) Are you experiencing pain at the affected area? Yes / No
If Yes: rate your pain (please circle)
1 2 3 4 5 6 7 8 9 10
very mild ----------→ moderate----------→worst possible
Describe your pain: intermittent / constant / sharp / dull / burning / pressure / awaken you at night / radiate
Over the past two weeks, has your pain: improved / worsened / stayed the same
What activities/movements aggravate your pain (circle all applicable)?
climbing stairs / walking / running / lifting / throwing a ball / dressing / working / reaching for a seat-belt / getting up from a chair / shaking hands
other_____
List any activities or medications that make the pain better:
_____

4) Have you seen any other orthopaedic doctors for this problem? Yes / No
If Yes, when: _____
Any treatments? brace cortisone injection NSAID Medrol dose pack physical therapy surgery

5) Have you had any tests for this problem (circle)?
X-Rays MRI CT scan Arthrogram Blood Tests EMG Ultrasound
Date and location of any tests and results, if known:_____
_____

GENERAL MEDICAL INFORMATION
Right-handed / Left-handed (circle)
Have you been diagnosed with any of the following (circle)?

Yes / No Alcoholism	Yes / No Heart Disease
Yes / No Mitral Valve Prolapse / Murmurs	Yes / No Arthritis (location)_____
Yes / No Asthma Yes / No Hepatitis	Yes / No Blood Clots / DVT
Yes / No HIV Positive	Yes / No Cancer (Type)_____
Yes / No Diabetes	Yes / No Osteoporosis
Yes / No Parkinsonism	Yes / No Drug Addiction
Yes / No Peptic ulcers	Yes / No Reflux
Yes / No Psoriasis	Yes / No Gout

PLEASE TURN PAGE OVER ----------→

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Name:_____Age:_____Birthdate:_____

Have you been diagnosed with any of the following (circle)?

Yes / No Stroke
Yes / No Thyroid Disease
Yes / No Blood Diseases (Anemia, Leukemia)
Yes / No High Blood Pressure
Yes / No High Cholesterol
OTHER MEDICAL PROBLEMS:_____
Yes / No Fractures/broken bones (where / when?)_____

Past Surgeries (please list below and provide date, surgeon, hospital/city if known):

_____
_____

Family History

Do you have any immediate family members with the following (please circle):

Diabetes Cancer High Blood Pressure Gout Heart Disease

Father's Health (circle): Good / Fair / Poor / Deceased (cause)_____
Mother's Health (circle): Good / Fair / Poor / Deceased (cause)_____

Social History

Do you exercise / play sports regularly? Yes / No
If yes, what kind of exercise / sport and how often?_____
Are you currently (please circle): Employed Unemployed Retired Disabled
Occupation:_____Please list your employer or if you are self-employed:_____
If you are a student, please list your grade/year and school:_____
Do you smoke or chew tobacco? Never / Current / Previous year quit?_____
Do you drink any alcoholic beverages? Yes / No If yes, what and how often?_____
For women in childbearing years: pregnant now / possibly pregnant / highly unlikely / can't be pregnant

Review of Systems: Please circle below if you experience any of the following symptoms

Fever	Chills	Headaches
Blurred vision	Double vision	Pain of mouth/gums or teeth
Partial/Complete vision loss	Ringing in the ears	Excessive fatigue
Hearing aid usage	Nose bleeds	Abdominal pain
Seasonal allergies	Sinus infections	Excessively cold
Difficulty swallowing	Hoarseness/voice change	Pain with breathing
Neck lumps/swelling	Speech difficulty	Night leg cramps
Palpitations	Excessive sweating	Nausea
Vomiting	Diarrhea	Constipation
Hemorrhoids	Excessive thirst	Excessive urination
Urinary retention	Memory loss	Varicose veins
Panic attacks	Depression	Insomnia
Easy bruising / bleeding	Food allergies	Urinary tract infections
Abnormal weight loss/gain	Frequent toothache	Chest pain
Swelling of extremities	Shortness of breath	Skin lesions / rashes
Urinary incontinence	Vertigo / Imbalance	Change in bowel/bladder habits
Tremors	Clumsiness/lack of coordination	

Is your primary care provider aware of any issues reported above? Yes / No

Thank you for completing this form.

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