WORCESTER COUNTY
ORTHOPEDICS

NEW PATIENT HISTORY FORM

TODAY'S DATE: _____ / _____ / _____ DATE OF BIRTH: _____ / _____ / _____ AGE: _____ HT: _____ WT: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

CHIEF COMPLAINT: What is the main reason for your visit today? _____

HISTORY OF PRESENT ILLNESS

Date of Accident or Date Symptoms Began:
_____ / _____ / _____

Location of the Problem: R L Both
Area: _____

Was this a work-related accident? Yes No
Was this an auto accident? Yes No
Recreational or school athletic injury? Yes No
Accident in your home? Yes No
Accident other than above? Yes No
Explain: _____

Are you currently working? Yes No N/A
If yes, are you working: Full duty or Limited duty
Occupation: _____

Explain Injury or Problem: _____

Describe the symptoms you are having: _____

Are the symptoms/problem constant or variable?
Dull then sharp? Very sharp then leaves? Constant?
Other: _____

How long do the symptoms/problem last?
Seconds Minutes Hours Always Present
Other: _____

Does anything make the symptoms/problem worse?

Does anything make the symptoms/problem better?

Is anything else occurring at the same time?
No Yes – If yes, please explain: _____

List any other doctors you have seen for this problem:

List any previous tests or procedures for this problem:

Does the problem interfere with you normal functions?
No Yes – If yes, please explain: _____

PAST MEDICAL, FAMILY & SOCIAL HISTORY

List any personal illness and medical condition for which you are treated (current and past):

List any surgeries and date occurred:

Do you have any drug allergies?
No Yes (If yes, please explain)

Drug	Reaction

List all serious illnesses in your immediate family (Example: blood clots, diabetes, cancer, heart disease, etc.):

	Relation

Please list all medications you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do/Did you smoke? Yes No

If yes, how much? _____

If yes, how long? _____

Do/Did you drink alcohol? Yes No

If yes, how much? _____

Are you right or left handed? R L

Do you exercise regularly? Yes No

If yes, how much? _____

What exercises: _____

_____

_____

If age 55 or older, have you ever had a Bone Density Test? Yes No

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following systems? Circle Yes or No

Constitutional Symptoms

Fever	Yes	No
Chills	Yes	No
Headache	Yes	No
Change in appetite, weight, energy	Yes	No

Other: _____

Integumentary

Skin Rash	Yes	No
Boils	Yes	No
Persistent Itch	Yes	No

Other: _____

Eyes

Blurred Vision	Yes	No
Double Vision	Yes	No
Pain	Yes	No

Other: _____

Musculoskeletal

Neck Pain	Yes	No
Joint Swelling/Pain	Yes	No
Back Pain	Yes	No
Bone Pain	Yes	No

Other: _____

Allergic/Immunologic

Hay Fever	Yes	No
Drug Allergies	Yes	No
Food Allergies	Yes	No

Other: _____

Ear/Nose/Throat/Mouth

Ear Infection	Yes	No
Sore Throat	Yes	No
Sinus Problem	Yes	No
Bleeding Ears, Nose, Gums	Yes	No

Other: _____

Neurological

Tremors	Yes	No
Dizzy Spells	Yes	No
Numbness/Tingling	Yes	No
Seizures	Yes	No

Other: _____

Genitourinary

Urine Retention	Yes	No
Painful Urination	Yes	No
Urinary Frequency	Yes	No
Change in Urine Stream	Yes	No

Other: _____

Endocrine

Excessive Thirst	Yes	No
Too Hot/Cold	Yes	No
Tired/Sluggish	Yes	No

Other: _____

Respiratory

Wheezing	Yes	No
Frequent Cough	Yes	No
Shortness of Breath	Yes	No

Other: _____

Gastrointestinal

Abdominal Pain	Yes	No
Nausea/Vomiting	Yes	No
Indigestion/Heartburn	Yes	No
Change Stool Size/ Shape/Color	Yes	No
Pain with Swallowing	Yes	No
Hepatitis	Yes	No

Other: _____

Hematologic/Lymphatic

Swollen Glands	Yes	No
Blood Clotting Problem	Yes	No
On Blood Thinners	Yes	No
Prior Blood Transfusions	Yes	No
HIV	Yes	No

Other: _____

Cardiovascular

Chest Pain	Yes	No
Rapid Heart Rate	Yes	No
Slow Heart Rate	Yes	No
Pacemaker	Yes	No
High Blood Pressure	Yes	No

Other: _____

How long did it take to get an appointment? ☐ 1 Day ☐ Days ☐ 1 Week ☐ Weeks

List any problems or difficulties you had in scheduling your visit with us: _____

_____