Reset Form

Print Form

Orthopaedics New Patient Information

Date

Name _____ Age _____ Sex _____

Occupation _____

Referring Physician Name _____ Clinic _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ email _____

Primary Care Provider Name _____ Clinic _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ email _____

What are we seeing you for today? _____

What is your goal for this visit? _____

Is this a work related injury? _____ If yes, list your OWCP or L&I Claim # _____

If disabled, what was the last day you worked? _____

PAIN

Location: Where on your body is your pain? _____

What is the quality of your pain? (describe) _____

On an average day, what is your pain level? _____
< 1 = No Pain 10 = Worst Pain >

On an bad day, what is your pain level? _____
< 1 = No Pain 10 = Worst Pain >

What makes your problem or pain better?

PT.NO

NAME

DOB

UW Medicine
Harborview Medical Center – UW Medical Center
University of Washington Physicians
Seattle, Washington

ORTHOPAEDIC NEW PT INFORMATION

H1947
HMC1947 REV FEB 07

What makes your problem or pain worse?

What makes your pain or problem change? Is it associated with anything else?

What provider is managing your pain?

History of Present Illness

Where is the problem located?

When and how did this injury begin?

What studies have you had ? ☐ X-rays ☐ CT ☐ MRI ☐ Nerve Study ☐ EMG ☐ Arthrogram ☐ Bone Scan

Have you had previous surgery for this injury or condition?

If "YES" include when, where, name of surgeon and did the surgery help.

Past Medical History

Are you allergic to latex? ☐ Yes ☐ No Are you alleric to iodine? ☐ Yes ☐ No

Do you have allergies? ☐ Yes ☐ No If YES to allergies, describe reactions

List all medications you now take. Include name, dose and frequency

Name		Dose		Frequency	
Name		Dose		Frequency	
Name		Dose		Frequency	
Name		Dose		Frequency	
Name		Dose		Frequency	
Name		Dose		Frequency	
Name		Dose		Frequency	
Name		Dose		Frequency	
Name		Dose		Frequency	

List all past surgeries you have had in the past, including any complications (bleeding, infection, blood clots, etc.

Surgeries _____ Complications _____

Surgeries _____ Complications _____

Surgeries _____ Complications _____

Surgeries _____ Complications _____

Surgeries _____ Complications _____

Have you ever smoked or used tobacco products? ☐ Current ☐ Former ☐ Never Smoked

Are you interested in quitting? ☐ Yes ☐ No If "YES" when?

Do you consume alcohol? ☐ Yes ☐ No If "YES" How many drink do you consume a week? _____

Do you currently or have you ever had a problem with drug or alcohol abuse? ☐ Yes ☐ No

Family History

Has any of your family members had the following? ☐ Arthritis ☐ Cancer ☐ Depression ☐ Diabetes

☐ Gout ☐ Heart Attack ☐ Hypertension ☐ Kidney Disorder ☐ Rheumatoid Arthritis ☐ Stroke ☐ Other

Social History

Are you currently working? ☐ Yes ☐ No What is your current occupation? _____

Are you married? ☐ Yes ☐ No ☐ Other Relationship Number of children? _____

How many individuals do you currently live with? _____

Problems

Do you have or have you had any of the following problems? (check all that apply)

General: ☐ Weight Gain ☐ Weight Loss ☐ Fatigue ☐ Insomnia

Eyes: ☐ Glasses/Contacts ☐ Cataracts ☐ Glaucoma

Ear/Nose/Throat: ☐ Sinus Trouble ☐ Hearing Loss ☐ Ringing

Heart: ☐ Irregular Heartbeat ☐ High Blood Pressure ☐ Chest Pain ☐ Fluttering in Chest ☐ Coronary Artery Disease

Stomach: ☐ Decreased appetite ☐ Constipation ☐ Heartburn ☐ Nausea ☐ Diarrhea ☐ Hepatitis A, B, or C

Muscles/Bones: ☐ Arthritis ☐ Fractures ☐ Sprains

Lungs: ☐ Shortness of Breath ☐ Lung Disease ☐ Persistent Cough

Urinary Tract: ☐ Kidney Stones ☐ Bladder or Kidney Infections ☐ Prostrate Problems

Mental Health: ☐ Anxiety ☐ Depression ☐ Other

Skin: ☐ Masses ☐ Blisters ☐ Dermatitis ☐ Eczema

Neurology: ☐ Problems with Swallowing ☐ Seizures ☐ Tingling ☐ Numbness ☐ Severe Headache

Endocrine: ☐ Increased Thirst ☐ Diabetes ☐ Thyroid

Blood Lymph: ☐ Bleeding or Clotting Problems ☐ Anemia ☐ Swollen or Enlarged Lymph Nodes

Immunological: ☐ Hay Fever ☐ Lupus ☐ HIV/AIDS

List any other medical problems you have been treated for (indicate which ones required hospitalization

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To be completed by Clinic Staff

B/P _____ Pulse _____ Resp _____ Ht _____ Wt _____

Presence Statement

I saw and evaluated the patient with (resident/fellow) _____

We discussed the patient's case as outlined in the (ACE/Resident/Fellow) notes

I ☐ Do ☐ Do not concur with the evaluation and add the following (comments/modification)

☐ I was present for or participated in the critical or key portion(s) and I was immediately available for the remainder of the procedure(s).

Physician's Name: _____ Physician's Signature: _____

Pager: _____ UPIN: _____ Date: _____ Time: _____