BRIGHAM AND WOMEN'S HOSPITAL
A Teaching Affiliate of Harvard Medical School
75 Francis Street, Boston, Massachusetts 02115

PATIENT IDENTIFICATION AREA

Orthopedic Surgery
New Patient Self Assessment Form

TELL US ABOUT YOURSELF

Patient Name: _____ Date of Birth: _____

Phone: _____ Best time to call: _____

PRIMARY CARE MD: _____ **REFERRING MD:** _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

PRESENT HISTORY

Chief Complaint: _____

Reason for today's visit: _____

How long have you had this problem? _____

Do you have any pain as a result of this problem? ❒ Yes ❒ No

If yes, on a scale of 1-10, 10 being the greatest, how would you describe this pain? _____

What makes your problem better / worse? _____
(lying, bending, sneezing, standing, lifting, walking, sitting, coughing) or (rest, exercise, sitting, lying down, other)

Current Limitations: _____

Current problem is the result of a(n): ❒ Car Accident ❒ Work Accident ❒ Accident ❒ Other
(Check all that apply)

Date of Injury: _____

Previous treatments other than surgery: _____

Previous surgery for this problem: _____

PAST HISTORY

Please list any prior illnesses and /or injuries:

_____

_____

Are you under the care of a Cardiologist: ❒ Yes ❒ No Name: _____

Address/Location: _____

Phone: _____

Have you ever had problems with anesthesia in the past? ❒ Yes ❒ No

If yes, please explain: _____

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SURGICAL HISTORY

SURGERIES / HOSPITALIZATIONS	YEAR	COMPLICATIONS

MEDICATIONS - **(INCLUDE OVER THE COUNTER MEDICATIONS, FOR EXAMPLE VITAMINS, ASPIRIN ETC.)**

CURRENT MEDICATION(S)	DOSE	FREQUENCY

Allergies to Medications (list medication and reaction): _____

_____

_____

Latex Allergy: ❒ Yes ❒ No

Other Allergies (list allergy and reaction): _____

_____

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FAMILY HISTORY

Is there any history in your family of

Gout: ☐ No ☐ Yes, Who? _____

Rheumatoid Arthritis: ☐ No ☐ Yes, Who? _____ Cardiac Issues: ☐ No ☐ Yes, Who? _____

Other Significant Orthopedic Problems: ☐ No ☐ Yes, Who? _____

SOCIAL HISTORY

Occupation: _____

How long have you been at your current job? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No How many? _____

Do you live alone? ☐ Yes ☐ No Who lives with you? _____

Do you smoke?
☐ Yes, I've smoked _____ packs of cigarettes per day for _____ years.
☐ Yes, I smoke cigars or a pipe.
☐ No, I have never smoked.
☐ No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

Do you drink alcohol?
☐ No, never (or rarely) ☐ No, but I used to
☐ Yes How Often? ☐ Daily ☐ 1 or more times/week ☐ 1 or more times/month

Have you lost or gained more than 10 pounds in the last 3 months without trying or wanting to lose weight?
☐ Yes ☐ No

Have you had any difficulties with the following:

Eating / drinking / swallowing	☐ Yes ☐ No	Getting into or out of bed	☐ Yes ☐ No	History of falls	☐ Yes ☐ No
Hygiene	☐ Yes ☐ No	Walking	☐ Yes ☐ No		
Dressing	☐ Yes ☐ No	Toileting	☐ Yes ☐ No		

Do you exercise regularly? ☐ Yes ☐ No

What exercise do you do? _____

How Often? _____

Is there anything that restricts you from doing the activities you want to do? ☐ Yes ☐ No

Have you ever felt unsafe or been afraid of anyone? ☐ Yes ☐ No

PATIENT SAFETY EDUCATION

Did you receive a copy of the We Care About Your Safety brochure? ☐ Yes ☐ No

Do you understand how to prevent the spread of germs? ☐ Yes ☐ No

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REVIEW OF SYSTEMS

Are you currently, or have you ever had problems with:

HOW YOU FEEL	CIRCLE ONE	
Fever	Yes	No
Unexpected Weight Loss	Yes	No
Excessive Fatigue	Yes	No
Night Sweats	Yes	No
Loss of appetite	Yes	No
YOUR EYES		
Wear Glasses or Contacts	Yes	No
Infections	Yes	No
Injuries	Yes	No
YOUR EAR, NOSE, THROAT & MOUTH		
Wear Hearing Aids?	Yes	No
Date of last Exam:_____		
Hearing Loss	Yes	No
Ear Infections	Yes	No
Balance Disturbance	Yes	No
Sinus Problems	Yes	No
YOUR HEART		
Chest Pain or Angina	Yes	No
Date of Last EKG:_____		
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
Heart Attack	Yes	No
Blood Clots	Yes	No
YOUR LUNGS		
Asthma	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung Cancer	Yes	No
Tuberculosis	Yes	No
Sleep Apnea	Yes	No
YOUR STOMACH & INTESTINES		
Nausea	Yes	No
Vomiting	Yes	No
Ulcers or Gastritis	Yes	No
Colon Cancer	Yes	No
Stomach Ulcer	Yes	No
Hepatitis	Yes	No
YOUR KIDNEYS & URINE		
Urinary Tract Infections	Yes	No
Kidney Stones	Yes	No
Kidney Disease	Yes	No

YOUR MUSCLES & BONES	CIRCLE ONE	
Broken Bones	Yes	No
List:_____		
Arm or Leg Weakness	Yes	No
Back Pain	Yes	No
Arm or Leg Pain	Yes	No
Joint Pain or Swelling / Arthritis	Yes	No
Numbness	Yes	No
Osteoporosis	Yes	No
Instability / giving way / dislocation	Yes	No
Stiffness	Yes	No
Scoliosis	Yes	No
Spinal Conditions	Yes	No
YOUR SKIN		
Skin Cancer	Yes	No
Skin Ulcers	Yes	No
YOUR BRAIN & NERVES		
Fainting Spells or "Blacking Out"	Yes	No
Seizures	Yes	No
Coordination in Arm and / or Legs	Yes	No
Stroke	Yes	No
Balance Problem	Yes	No
Headaches	Yes	No
YOUR GLANDS		
Diabetes	Yes	No
Treatment_____		
Thyroid Disease / Disorder	Yes	No
Hormone Problems	Yes	No
YOUR BLOOD		
Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands/Lymph Nodes	Yes	No
Blood Transfusion	Yes	No
If yes, when?_____		
Easy bleeding	Yes	No
Easy bruising	Yes	No
Cancer	Yes	No
YOUR ALLERGIES & IMMUNE SYSTEM		
Inhalant (Nasal) Allergies	Yes	No
Immunologic Disorders	Yes	No
YOUR FEELINGS		
Anxiety	Yes	No
Depression	Yes	No
Other Psychiatric Disorder	Yes	No
Treatment:_____		

I believe that my answers are correct . _____ Sign your name and put today's date and time	I have reviewed the above information with the patient. _____ Physician's Name Date Time _____ Physician's Signature