Chart #

POTOMAC VALLEY
ORTHOPAEDIC ASSOCIATES
C H A R T E R E D

GEORGE YEH, MD
Orthopaedic Surgery
Hand & Upper Extremity Surgery

New Patient & New Problem History Form

Name ______________________________ Date ________________

Were you referred here? ☐ No ☐ Yes→ by whom ____________________

Age _____ Height __________ Weight __________

☐ Right handed ☐ Left handed ☐ Ambidextrous Occupation _______________________

- What is the reason for the visit? ☐ injury ☐ pain ☐ numbness ☐ mass ☐ other ________________
- Where is the problem? ☐ Right ☐ Left Area of body _________________________
- When did the problem begin? _______________________
- How did the problem start? ☐ sports ☐ fall ☐ car accident ☐ work related ☐ no specific injury

  Please explain: ____

- What kind of pain do you feel? ☐ sharp ☐ dull ☐ burning ☐ throbbing ☐ aching ☐ none
- How severe are the symptoms? ☐ mild ☐ moderate ☐ severe
- How often do the symptoms occur? ☐ intermittent (on and off) ☐ constant ☐ when sleeping at night
- What makes the problem worse? ☐ work/job ☐ writing ☐ computer ☐ driving ☐ ______________
  ☐ exercise ☐ lifting ☐ bumping ☐ gripping ☐ opening jars
- Symptoms include ☐ pain ☐ weakness ☐ swelling ☐ stiffness ☐ numbness/tingling ☐ neck pain
- What is your work status (if applicable)? ☐ regular duty ☐ light duty ☐ not working due to problem
- Since the problem started, it is ☐ getting better ☐ not improving ☐ getting worse
- Which treatments have you tried?

  ☐ rest improvement? ☐ yes ☐ no
  ☐ medications (which ones?) _______________ improvement? ☐ yes ☐ no
  ☐ splint (what kind?) _______________ improvement? ☐ yes ☐ no
  ☐ therapy (how long?) _______________ improvement? ☐ yes ☐ no
  ☐ injection (how many?) _______________ improvement? ☐ yes ☐ no
  ☐ surgery (what and when?) _______________ improvement? ☐ yes ☐ no

- What are your interests and hobbies? ____

*** Please go to Page 2 ***

Name:

Dr Yeh Form Page 2

Medical History (your health issues)

☐ **None / Healthy**
☐ High blood pressure
☐ Heart disease
☐ Diabetes
☐ Asthma
☐ Thyroid disease
☐ Acid reflux
☐ Cancer
☐ Stroke
☐ Kidney disease
☐ Liver disease
☐ Other ____________

Allergies to medications

☐ **None known**
☐ Penicillin
☐ Sulfa
☐ Aspirin
☐ Codeine
☐ Other _______________

Surgical History (your major surgeries)

☐ **None**

____________________ date _____
____________________ date _____
____________________ date _____
____________________ date _____

Medications (your current medications)

☐ **None**

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____

Family History
(what runs in your family?)

☐ **None**
☐ Heart disease
☐ Diabetes
☐ Cancer
☐ Arthritis

Social History

Smoking: ☐ no ☐ yes ___ packs/day
Alcohol:
☐ none ☐ social ☐ frequent
Marital status:
☐ single ☐ married ☐ divorced
☐ widowed ☐ separated

Do you currently experience any of the following? (check all that apply)

General
☐ use cane/walker
☐ high cholesterol
☐ fevers

Cardiovascular
☐ irregular heartbeat
☐ heart murmur
☐ pacemaker

Gastrointestinal
☐ stomach ulcers
☐ heartburn
☐ hepatitis

Musculoskeletal
☐ osteoporosis
☐ arthritis
☐ gout

Neurologic
☐ headaches
☐ seizures
☐ neuropathy

Eyes
☐ need glasses
☐ glaucoma

Ears/Nose/Throat
☐ sinus infections
☐ hearing loss

Respiratory
☐ COPD
☐ sleep apnea

Urinary
☐ urinary infection
☐ renal failure

Endocrine
☐ hormone problems
☐ recent pregnancy

Skin
☐ lymphedema
☐ psoriasis

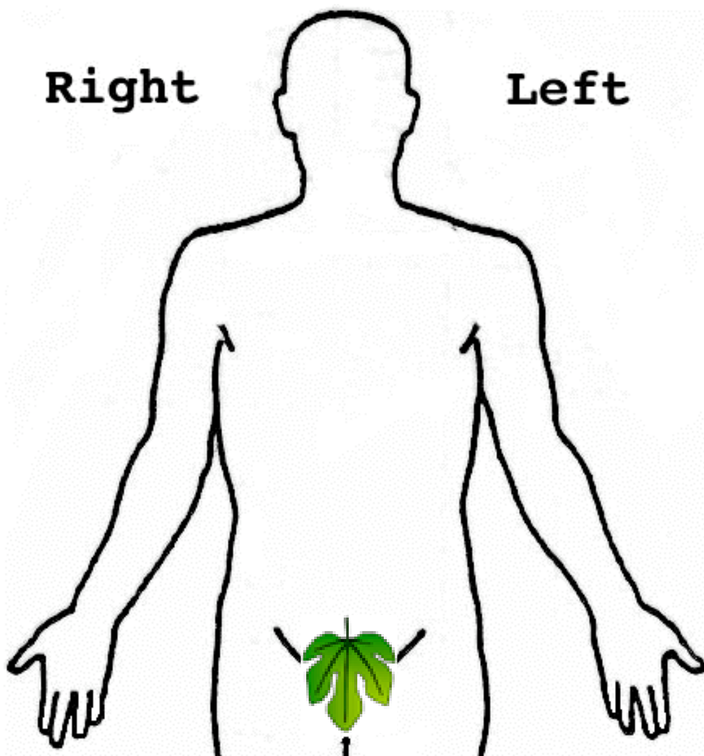
Hematologic
☐ bleeding problems
☐ blood clots

Immunologic
☐ immunocompromise
☐ tuberculosis

Psychiatric
☐ depression
☐ anxiety

☐ **NONE OF ABOVE**

On the diagram below, please mark the area of your problem.



To the best of my knowledge, the information is accurate.

Patient signature: ____________________ Date: _____