

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 reason

Please explain: \_\_\_\_\_

• Symptoms include  pain  weakness  swelling  stiffness  numbness/tingling  neck pain

• 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?  on and off  constant  while sleeping  upon waking up

• What aggravates the problem?  opening jar  lifting  gripping  pressure  \_\_\_\_\_  
 work/job  writing  computers  driving  exercising  shopping  using TV remote

• 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?

- |  |   |
|--|---|
| <input type="checkbox"/> rest                          | improvement? <input type="checkbox"/> yes <input type="checkbox"/> no |
| <input type="checkbox"/> medication (which one?) _____ | improvement? <input type="checkbox"/> yes <input type="checkbox"/> no |
| <input type="checkbox"/> splint (what kind?) _____     | improvement? <input type="checkbox"/> yes <input type="checkbox"/> no |
| <input type="checkbox"/> therapy (how long?) _____     | improvement? <input type="checkbox"/> yes <input type="checkbox"/> no |
| <input type="checkbox"/> injection (how many?) _____   | improvement? <input type="checkbox"/> yes <input type="checkbox"/> no |
| <input type="checkbox"/> magnets, voodoo, other _____  | improvement? <input type="checkbox"/> yes <input type="checkbox"/> no |

• What activities and interests do you enjoy? \_\_\_\_\_

Name: \_\_\_\_\_

# Dr Yeh Form Page 2

### Medical History (your health issues)

- None / Healthy
- High blood pressure
- Heart disease
- Diabetes
- Asthma
- Thyroid disorder
- 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

*Have you experienced any of the following? (elaborate as needed)*

#### General

- allergy to pain
- use cane/ walker
- fevers

#### Cardiovascular

- irregular heartbeat
- heart murmur
- pacemaker

#### Respiratory

- anesthesia problem
- COPD
- sleep apnea

#### Musculoskeletal

- fractures
- arthritis
- gout

#### Neurologic

- headaches
- seizures
- neuropathy

#### Endocrine

- recent pregnancy
- osteoporosis

#### Eyes

- wear glasses
- glaucoma

#### Gastrointestinal

- stomach ulcer
- hepatitis

#### Hematologic

- bleeding problem
- blood clot

#### Psychiatric

- depression
- anxiety

#### Skin

- lymphedema
- psoriasis

#### Ears/Nose/Throat

- sinus infection
- hearing loss

#### Urinary

- urinary infection
- renal failure

#### Immunologic

- immunocompromise
- tuberculosis

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: \_\_\_\_\_

