Chart #

The Centers for Advanced Orthopaedics
Potomac Valley Orthopaedic Associates

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 obvious cause

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? ☐ intermittent ☐ constant ☐ while sleeping ☐ upon waking up

• What makes it worse? ☐ opening jar ☐ twisting ☐ lifting ☐ gripping ☐ pressure ☐ _____
☐ work ☐ phone ☐ computer ☐ reading ☐ writing ☐ driving ☐ exercise ☐ opening door

• 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	help?	☐ yes	☐ no	☐ partial
☐ medication (which one?) _____	help?	☐ yes	☐ no	☐ partial
☐ splint/ brace (what kind?) _____	help?	☐ yes	☐ no	☐ partial
☐ therapy (how long?) _____	help?	☐ yes	☐ no	☐ partial
☐ injection (how many?) _____	help?	☐ yes	☐ no	☐ partial
☐ magnets, chicken soup, other _____	help?	☐ yes	☐ no	☐ partial

• What activities and interests do you enjoy? _____

*** 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 disorder
- ☐ Acid reflux
- ☐ Cancer
- ☐ Stroke
- ☐ Kidney failure
- ☐ Liver disease
- ☐ Other _____

Allergies to medications

- ☐ **None known**
- ☐ Penicillin
- ☐ Sulfa
- ☐ Aspirin
- ☐ Codeine
- ☐ Other _____

Surgical History (your major surgeries)

☐ **None**

_____ date _____
_____ date _____
_____ date _____
_____ date _____

Medications (including supplements)

☐ **None**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family History
(what runs in your family?)

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

Social History

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

Have you seen an orthopedic doctor in the last 3 years? ☐ No ☐ Yes→ Dr. _____

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

General
- ☐ difficulty w/ needles
- ☐ use cane/ walker
- ☐ chronic pain

Cardiovascular
- ☐ irregular heartbeat
- ☐ heart murmur
- ☐ pacemaker

Respiratory
- ☐ anesthesia problem
- ☐ COPD
- ☐ sleep apnea

Musculoskeletal
- ☐ previous fracture
- ☐ arthritis
- ☐ gout

Neurologic
- ☐ headaches
- ☐ seizures
- ☐ neuropathy

Endocrine
- ☐ recent pregnancy
- ☐ osteoporosis

Eyes
- ☐ cataract surgery
- ☐ glaucoma

Gastrointestinal
- ☐ stomach ulcer
- ☐ hepatitis

Hematologic
- ☐ easy bleeding
- ☐ blood clot

Psychiatric
- ☐ depression
- ☐ anxiety

Skin
- ☐ lymphedema
- ☐ psoriasis

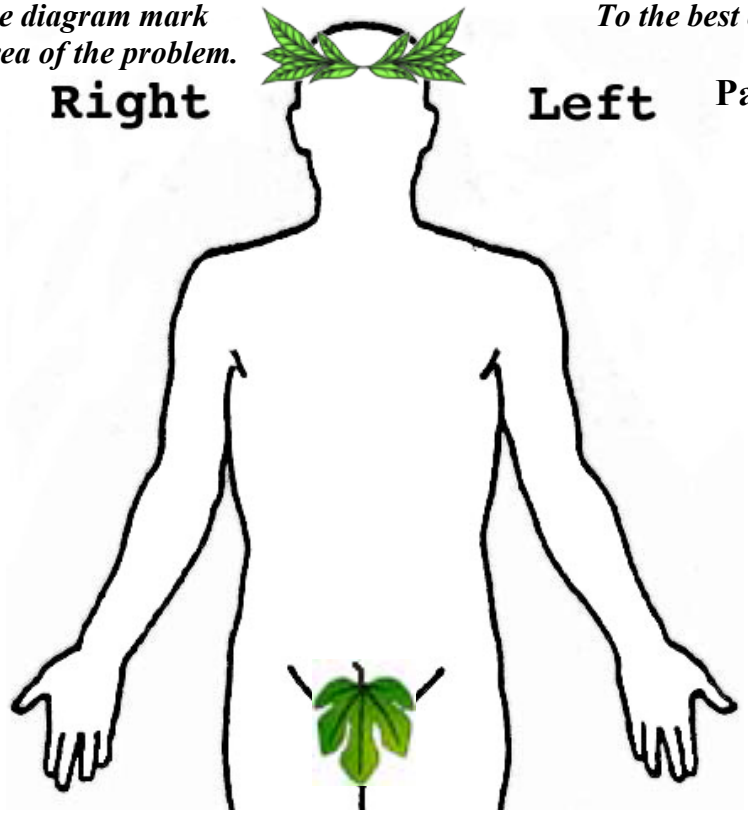
Ears/Nose/Throat
- ☐ sinus infection
- ☐ hearing loss

Urinary
- ☐ urinary infection
- ☐ kidney stones

Immunologic
- ☐ immunocompromise
- ☐ latex/ metal allergy

☐ **NONE OF ABOVE**

On the diagram mark the area of the problem.



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

Patient signature: _____

Date: _____