Tufts Medical Center

Department of Orthopaedics
New Patient Evaluation Form

Name: _____ Age: _____ Phone Number: _____

Referring MD: _____ Primary Care Physician: _____

Height: _____ Weight: _____ Allergies: _____

Date of Injury: _____

Were you hurt at work? ☐ Yes ☐ No Dominant hand? ☐ Right ☐ Left

Please describe the reason for your visit: ☐ Left ☐ Right _____

What happened? _____

What makes it better? _____

What makes it worse? _____

Have you seen another MD for this condition? ☐ Yes ☐ No Whom/When:_____

Were you seen in the Emergency Room for this condition? ☐ Yes ☐ No

Did you have diagnostic testing for this condition? : ☐ X-RAY ☐ MRI ☐ CT scan

Past Medical History: Please circle any of the following that apply to you

Abnormal Bleeding	Epilepsy/Seizures	Kidney Disease
Anxiety/Depression	Fractures/Broken Bones	Liver Disease
Arthritis	Gout	Neck Pain
Asthma	Heart Attack	Blood Clot
Back Pain	Heart Disease	Rheumatoid Arthritis
Blood Clots	Hepatitis	Stroke/Paralysis
Cancer	High Blood Pressure	Substance Abuse
Diabetes	HIV/Aids	Thyroid Disease

Other: _____

Past Surgical History: Please circle any of the following that apply to you and include date of surgery

Appendectomy	Pacemaker	Knee Arthroscopy
Breast Surgery	Shoulder Arthroscopy	No Past Surgery
Cancer Surgery	Vascular Surgery	Blood Clot
Cardiac Bypass	Hip replacement	
Hand Surgery	Knee Replacement	

Other: _____

PLEASE FILL OUT BOTH SIDES OF THIS PAPERWORK

Tufts Medical Center

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student
Occupation: _____

Smoker: ☐ Yes ☐ No ☐ Formerly If yes, how many packs per day? ___ # of years? _____

Alcohol: ☐ Yes ☐ No If yes, how many drinks per week? _____

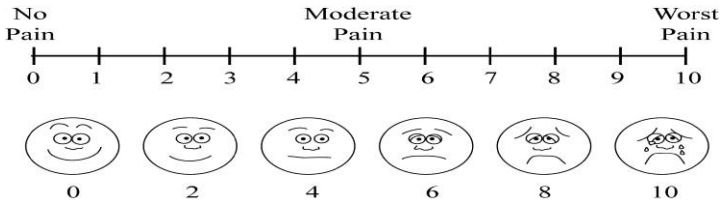
Family History: Mother (M), Father (F), Siblings (S), Other (O)

Arthritis ____	Kidney Disease ____	Diabetes ____
Stroke ____	Pulm. Embolism ____	Thyroid ____
Osteoporsis ____	Hypertension ____	Heart Disease ____
Cancer ____	Gout ____	Migrane ____
Liver Disease ____	Bleeding Disorder ____	Blood Clot ____

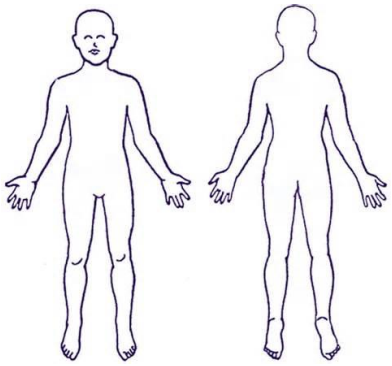
Review of Systems: Please circle any of the following that apply to you

Eyes (loss of vision)	Numbness/Tingling	Dental Problems
Ear, Nose, Throat	Anxiety/Depression	Joint/Muscle Pains/Cramps
Digestion, Stomach Bowel	Fever/Chills/Fatigue	Blackout/Fainting
Bladder Problems	Chest Pain/Tightness	
Bleeding Problems	Skin Rash	

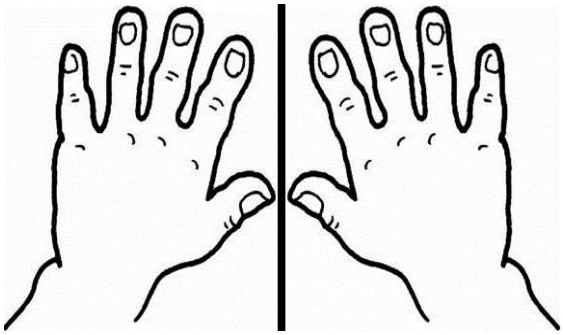
Please rate your pain:



Please mark area where you have pain:



Please mark area on hand where you have pain:



PLEASE FILL OUT BOTH SIDES OF THIS PAPERWORK