NEWTON-WELLESLEY HOSPITAL

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Patient Information Form

Name: _____ Date of Birth: _____ Date: _____

Primary Care Physician: _____ Who referred you: _____
Employer: _____ Occupation: _____
Reason For Visit: _____ Left ☐ Right ☐ Hand Dominance _____
Is this a work-related injury? ☐ Yes ☐ No If yes, when did the incident occur? _____

Height: _____ Weight: _____

Current Medications: (with doses) ☐ None

_____
_____

ALLERGIES: _____ ☐ None
Allergic to Penicillin ☐ Yes ☐ No

Past Surgical History: ☐ None

_____

_____

Past Medical History:

Diabetes	☐ Yes	☐ No	Blood Clot	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No

Social History:

Do you use Tobacco: ☐ Yes ☐ No Packs a day: _____
Alcohol: ☐ Yes ☐ No Drinks a week: _____
Do you or have you had a problem with chemical dependency: ☐ Yes ☐ No

Pain Scale: (Please circle one, 0=no pain, 10=excruciating) **0 1 2 3 4 5 6 7 8 9 10**

Review of Systems:

		Year	None
Constitutional	□Weight loss or gain □Loss of appetite □Bleeding problems		□
Eyes	□Blurred vision □Double vision □Vision loss		□
Ear/Nose/Throat	□Hearing loss □Hoarsness □Difficulty swallowing		□
Cardiovascular	□Chest pain □Palpitations □Heart Murmur		□
Respiratory	□Chronic cough □Shortness of Breath □Asthma		□
Gastrointestinal	□Heartburn/ulcers □Nausea/vomitting □Hepatitis/Liver disease □Blood in stool		□
Endocrine	□Thyroid disease □Heat/cold intolerance		□
Urinary	□Painful urination □Blood in urine □Kidney problems		□

Skin	□Frequent rashes □Psoriasis □Skin ulcers		□
Neurological	□Headaches □Dizziness □Seizures		□
Psychological	□Depression □Anxiety □Sleep disorder □Drug/Alcohol abuse		□
Hematology	□Easy bleeding □Easy bruising □Anemia		□

Patient Signature: _____ **Date:** _____

Description of Problem

In this section, check the ONE box which best describes how your problem started:

□No Injury **□ Injury** **□ Injury at Work**

□ Gradual onset | □ Sudden Onset □ Accident | □ Sport Date:_____ Date of Work Injury:_____

Please describe the problem briefly:_____

_____

_____

What is the *quality* of the pain? □ Sharp | □ Dull | □ Stabbing | □ Throbbing | □ Aching | □ Burning | □ None

The pain is: □ Constant | □ Intermittent (comes & goes) | □ Absent

Do you have: □ Swelling □ Bruising | □ Numbnes | □ Tingling | □ Weakness | □ Locking/Catching | □ Giving way?

Since my problem started, it is: □ Getting better | □ Getting worse | □ Unchanged

What makes your symptoms *worse*? □ Standing | □ Walking | □ Lifting | □ Exercise/Sports | □ Twisting | □ Lying in bed | □ Bending | □ Squatting | □ Kneeling | □ Sitting | □ Stairs | □ Other:_____

What makes your symptoms *better*? □ Rest | □ Elevation | □ Ice | □ Heat | □ Other: _____

Treatments for Problem

Have you had any of these treatments? □ Medication | □ Injection | □ Brace | □ Cane/Crtuches | □ Physical Therapy:

Physical Therapy Location: _____

Were you seen in the E.R. for this problem? □ No □ Yes, where? _____ **Date:** _____

What test/scans have you had for this problem? □ Xrays | □ MRI | □ CAT Scan | □ Bone Scan | □ Nerve Test

Have you ever had surgery for this problem or one in the same area? □ Yes □ No

Procedure: _____**Surgeon:**_____ **Date:**_____

Pain Medication Policy

1. I understand that the surgeons in SPORTS MEDICINE deal only with acute pain management for a short term post-operative period.

    a. After initial visit, pain medication will be obtained from the primary care physician or referring physician.
    b. I will be given pain medicine following knee and shoulder arthroscopy, ligament reconstruction, and shoulder replacement for two weeks after surgery in accordance with recommendations offered by the Acute Pain Service.

2. Pain medication refill requests will not be available after business hours or on weekends.

3. I understand it is my responsibility to inform the prescriber of any and all medications (prescribed and over the counter) that I am taking.

4. If the medication causes drowsiness, sedation or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in danger.

5. I agree to take this medication as prescribed and to not change the amount or frequency of the medication without discussing it with the prescriber. Running out early, needing early refills, escalating doses without permission and losing prescriptions may cause the prescriber to discontinue prescribing to me. Lost, stolen or damaged medication will not be replaced. I agree not to sell, lend, or in any way give my medication to another person.

6. I agree not to drink alcohol or take mood-altering drugs while I am taking opioid analgesic medication.

7. I also agree to participate in other pain treatment modalities recommended by my prescriber.

    a. Episodes of acute pain outside the postoperative period will be managed with physical therapy, over the counter analgesics or nonsteroidal anti-inflammatories, rest, ice, crutches, etc…
    b. Occasionally a hip or knee injection may be appropriate for an acute episode and will be determined on an individual basis.

8. Medications for chronic pain (pain requiring medication beyond the immediate postoperative period) will be referred back to the primary care physician or to a pain management clinic.

_____ _____

Signature of patient Date