NEWTON-WELLESLEY SPORTS MEDICINE

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2000 Washington St., Ste. 423 MOB Blue, Newton, MA 0246
Tel: 617.219.1280 / Fax: 617.219.1281

Patient Information Form

Name: _____ Date of Birth: _____ Date: _____

Primary Care Physician: _____ Who referred you: _____
Employer: _____ Occupation: _____
Reason For Visit: _____ Left ☐ Right ☐ Hand Dominance _____
Height: _____ Weight: _____

Current Medications (with dose): ☐ 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

Family History: (check if yes) ☐ Rheumatoid arthritis ☐ problems with anesthesia ☐ Diabetes
☐ Cancer If yes, type?_____ ☐ other_____

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

On a Scale of 0-10 (10 being the worst) how <u>severe</u> is your pain? (please circle one)
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 sto		□
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 abu		□
Hematology	□Easy bleeding □Easy bruising □Anemia		□

Patient Signature: _____ **Date:** _____

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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:**_____

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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

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Authorization for Disclosure of Health Information

(This form is optional to fill out and is valid for 1 year)

Patient's Name: _____ Date of Birth: _____

Patient Medical Record# (for office use only):_____

I authorize the staff of Newton Wellesley Sports Medicine to release my medical and/or billing information to the individuals listed below:

1._____ Relation to Patient: _____

2._____ Relation to Patient: _____

3._____ Relation to Patient: _____

I Understand:

- This authorization encompasses all protected health information, including sensitive information.
- I may revoke this authorization at any time by submitting a written notice of revocation to Newton Wellesley Sports Medicine. The revocation will be effective upon my receipt of written notice, except that it will not have any effect on any action already taken by Newton Wellesley Sports Medicine in reliance on this authorization.
- Once Newton Wellesley Sports Medicine has disclosed my health information to the recipient, the office cannot guarantee the recipient will not re-disclose my health information to a third party.
- This authorization will remain valid for 1 year from the date of signature.

Signature: _____ Date: _____
(Patient/guardian)

Witness: _____ Date: _____

Reminder Call Preferences

I authorize the staff of Newton-Wellesley Sports Medicine to leave voicemail messages to remind me of appointments and tests that have been ordered and scheduled for the benefit of my care. I understand that the content of those messages may include the date, time and location of appointments, as well as any tests that have been ordered. Reminder voicemails may be left on any one of the following phone numbers:

Tel#_____

Tel#_____

Tel#_____

Signature:_____ Date:_____
(Patient / Guardian)