ORTHOPAEDIC SPECIALISTS – UPMC
NEW PATIENT INFORMATION FORM

Name: _____ Date of Birth: _____ Age: _____

Primary Care Physician & Address

_____
_____
_____

Referring Physician & Address

_____
_____
_____

What is your dominant hand? Circle one R L
Reason for Today's Visit: _____
_____
_____
_____

Past Medical History	Yes	No	Detail Below (Check each section individually)
Heart Disease	_____	_____	_____
Kidney Disease	_____	_____	_____
Arthritis	_____	_____	_____
Diabetes Mellitus	_____	_____	_____
Cancer	_____	_____	_____
Thyroid Disease	_____	_____	_____
Bone/Joint/Muscle Disease	_____	_____	_____
Psychiatric or Behavioral Problems	_____	_____	_____
Deep Vein Thrombosis	_____	_____	_____
Eye, Ear, Nose, or throat Problem (ENT Disease)	_____	_____	_____
Lung Disease	_____	_____	_____
Liver Disease/ Hepatitis	_____	_____	_____
Muscular Dystrophy	_____	_____	_____
Seizure/ Epilepsy	_____	_____	_____
Peripheral Vascular Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Clotting Disorder	_____	_____	_____
Pulmonary Embolism	_____	_____	_____
Stomach/Intestinal/Ulcers	_____	_____	_____
Vascular Disease	_____	_____	_____
MRSA infection	_____	_____	_____

Past Hospitalizations (with dates): _____
_____
_____
_____

Family History: _____
_____
_____

Medications: _____
_____
_____

Allergies: Circle NONE or LIST: _____
_____

Social History (circle):

Alcohol Use	Yes	No	Amount/Duration: _____
Drug Use	Yes	No	Amount/Duration: _____
Tobacco Use	Yes	No	Amount/Duration: _____

Current Occupation: _____
Highest Level of Education: _____
Recreational Activities: _____

Past Surgical History	Yes	No	Detail Below (Check each section individually)
Craniotomy	_____	_____	_____
Intrathecal Pump	_____	_____	_____
Ventricular Shunt	_____	_____	_____
Spinal Cord Stimulator	_____	_____	_____
Thyroid Surgery	_____	_____	_____
Appendectomy	_____	_____	_____
Cholecystectomy	_____	_____	_____
Hysterectomy	_____	_____	_____
Shoulder Surgery	_____	_____	_____
Elbow Surgery	_____	_____	_____
Hand/Wrist Surgery	_____	_____	_____
Hip Surgery	_____	_____	_____
Knee Surgery	_____	_____	_____
Foot/ Ankle Surgery	_____	_____	_____
Spine Surgery	_____	_____	_____
Pacemaker	_____	_____	_____
ICD (implantable cardioverter defibrillator)	_____	_____	_____

SYSTEM REVIEW	**Yes**	**No**	**Explain**
Recent weight loss or gain	_____	_____	_____
Fever/chills/sweats/fatigue	_____	_____	_____
Headache/dizziness/blurred vision, corrective lens	_____	_____	_____
Chest pain/palpitation/irregular heartbeat	_____	_____	_____
Shortness of breath, coughing, sleep apnea/snoring	_____	_____	_____
Food or environmental allergies	_____	_____	_____
Heartburn/nausea/vomiting or diarrhea / constipation	_____	_____	_____
Frequent urination/burning	_____	_____	_____
Decreased sensation, numbness, tingling	_____	_____	_____
Easy bruising or bleeding disorder	_____	_____	_____
Excessive worry/anxiety, depression or trouble sleeping	_____	_____	_____
Excessive thirst or hunger/hair loss	_____	_____	_____
Changes in skin color or texture, unusual moles or rashes	_____	_____	_____
Swelling/discoloration/temperature change of extremity	_____	_____	_____

Patient Signature_____ **Date:**_____ **MD Signature**_____ **Date:** _____
_____ **Date:** _____

Worker's Compensation Information
(Complete *Only* if Applicable)

1. Date of work injury: _____
2. Injured part the claim covers: _____
3. Work title with brief description: _____
   _____
4. Currently working (Circle) Yes No
5. Current work restriction: _____
6. Last day worked: _____