



Orthopaedics
APD Multi-Specialty Clinic
Lebanon, NH 03766
Phone: (603) 442-5630 Fax: (603) 640-1979

John Houde, MD Diane Riley, MD Leonard Rudolf, MD Ivan Tomek, MD
Alexandra Angelo, PA-C Joel Dizon, PA-C Scott Mirick, PA-C Rebecca Van Dolah, PA-C

Dear _____

Thank you for choosing APD orthopaedics for your health care needs. Your appointment has been scheduled for:

_____ with: _____

Please arrive at _____ for registration and X-Rays (if needed). Please complete the enclosed patient questionnaire and return all forms to orthopaedics prior to your appointment. A postage-paid envelop is enclosed for your convenience or you may fax the forms to our office at (603) 442-5631. Thank you for choosing Alice Peck Day Orthopaedics.





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Demographic and Insurance Information

Patient Name: _____ **Date of Birth:** _____
(Last Name, First Name, Middle Initial) **Gender:** Male Female

Name of Parent/Guardian (if minor): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ (check preferred contact)

OK to leave a message: Yes No Email address: _____

Primary Care Physician: _____

Town: _____ PCP Phone #: _____

Primary Insurance Name: _____

Address: _____ Phone#: _____

ID # _____ Group #: _____

Subscriber Name: _____ DOB: _____

Secondary Insurance Name: _____

Address: _____ Phone#: _____

ID # _____ Group #: _____

Subscriber Name: _____ DOB: _____

Date form completed: _____



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Worker's Compensation Information

If you are being seen for an issue that is an active Worker's Compensation case, please complete the following. If not, skip to Work History below.

Employer Name: _____ Phone: _____

Address: _____

Date last worked: _____ Job Title: _____

W/C Insurance Carrier: _____ Phone: _____

Address: _____

Claim #: _____ Date of Injury: _____

Case Manager: _____ Phone: _____

Work History

Current work status: Full-time Part-Time Unemployed Retired

Current Employer: _____ Work Phone #: _____

Job title: _____

Length of time at current employer: _____

Maximum weight to lift/carry in your position: _____

Were you employed when your problem began? yes no

Is this a work related injury/problem? yes no

Have you filed a report of injury for this problem? yes no

Have you missed work as a result of this problem? yes no

Date last worked: _____

If applicable, please state how your injury occurred or how you feel this correlates to your employment?





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Current Concern

For insurance coverage purposes, please fill out this entire section

What condition are you being seen for?

_____ Right Left Both

What is your greatest concern regarding this condition? _____

When did the symptoms start? _____

How did the symptoms or condition start?

spontaneously, without injury or gradually, without injury or after an injury:

Explain: _____

How difficult has this problem(s) made it for you to work, take care of things at home, or do your usual recreation activities or hobbies:

not difficult at all somewhat difficult very difficult extremely difficult

What symptoms do you have? (check all that apply): catching changes in sensation

clicking cold sensitivity decreased range of motion decreased walking tolerance

instability joint pain locking night pain numbness popping snapping

stiffness swelling tingling weakness of affected extremity

other _____ none

What makes your symptoms worse? (check all that apply): climbing stairs

getting up from a chair gripping laying on it at night lifting

normal daily activities pinching prolonged walking raising arm running

sitting squatting throwing other _____ none

Do you use an assistive device? Cane Walker Wheelchair None

Have you tried any of the following treatments?

Supportive Care: ice/heat rest/elevation brace/wrap

Any improvement? no improvement slight improvement much improvement





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- Glucosamine/Chondroitin:** If yes, how long? _____
Any improvement? no improvement slight improvement much improvement
- Anti-inflammatory medications:** (such as ibuprofen/Advil/Motrin, naproxen/Aleve, meloxicam, Indocin or Toradol)
If yes, name(s) of medication: _____ How long? _____
Any improvement? no improvement slight improvement much improvement
- Gabapentin (Neurontin):** If yes, how long? _____
Any improvement? no improvement slight improvement much improvement
- Lyrica (Pregabalin):** If yes, how long? _____
Any improvement? no improvement slight improvement much improvement
- Narcotics** (such as Oxycodone, Vicodin, Suboxone, Dilaudid or Tramadol)
If yes, name(s) of medication: _____ How long? _____
Any improvement? no improvement slight improvement much improvement
Do you have a pain contract with another provider? yes no
If yes, with what provider (name and specialty): _____
- Therapies:** Physical Therapy Occupational Therapy Hand Therapy
If yes, where: _____ Date began: _____ How long: _____
Any improvement? no improvement slight improvement much improvement
- Joint Injections:** if yes, when: _____
Any improvement? no improvement slight improvement much improvement

Please check all of the following that you have had for this problem:

- X-rays Date _____ Location _____
- CT scan Date _____ Location _____
- MRI Date _____ Location _____
- EMG's Date _____ Location _____
- Vascular Studies Date _____ Location _____





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Please check all the following Specialists you have seen for this problem:

- Pain Specialist: Who _____ Where _____ When _____
- Rheumatologist: Who _____ Where _____ When _____
- Neurologist: Who _____ Where _____ When _____
- Cardiologist: Who: _____ Where _____ When _____
- Other Orthopaedist: Who: _____ Where _____ When _____

Medical History

Please check all conditions that you have been diagnosed with or a direct family member has been diagnosed with. If a family member, please write the relationship to you on the line provided:

	You	Family Member
Ankylosing Spondylitis:	<input type="checkbox"/>	<input type="checkbox"/> _____
Autoimmune Disease:	<input type="checkbox"/>	<input type="checkbox"/> _____
Gout:	<input type="checkbox"/>	<input type="checkbox"/> _____
Lupus:	<input type="checkbox"/>	<input type="checkbox"/> _____
Lyme Disease:	<input type="checkbox"/>	<input type="checkbox"/> _____
Osteoarthritis:	<input type="checkbox"/>	<input type="checkbox"/> _____
Pseudogout:	<input type="checkbox"/>	<input type="checkbox"/> _____
Rheumatoid Arthritis:	<input type="checkbox"/>	<input type="checkbox"/> _____
Congenital or Inherited Abnormality of Hand or Extremity:	<input type="checkbox"/>	<input type="checkbox"/> _____

Other medical history: (Please list any other conditions that you have been diagnosed with)

Have you ever had a Stress Test or Echo? yes no
 If yes, where _____ when _____

Which is your dominant hand? Right Left





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Surgical History

Please list all orthopaedic surgical procedures you have had: (please specify side)

Type _____ Where _____ Date _____

Type _____ Where _____ Date _____

Orthopaedic Hardware: (i.e. hip or knee replacements, rods, screws or plates)

Type _____ Where _____ Date _____

Other Surgical History: (Please list all other surgical procedures)

Type _____ Date _____

Type _____ Date _____

Type _____ Date _____

Type _____ Date _____

Medications

Please list all medications including over the counter medications, vitamins and supplements:

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy: _____

Town: _____ Phone: _____





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Allergies

Please list all allergies including medications, foods and environmental triggers:

Allergy	Reaction	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social History

Marital Status: _____ Spouse/Partner Name: _____

Do you smoke tobacco? current former never
If current or former, how much _____ per day, age started _____ age stopped _____

Do you drink alcohol? current former never
If current or former, how much _____ per week, age started _____ age stopped _____

Do you drink caffeinated beverages? current former never
If current or former, how much _____ per day, age started _____ age stopped _____

Do you use marijuana? current former never
If current or former, how much _____, age started _____ age stopped _____

Do you use other illicit drugs? current former never
If current or former, what type(s)? _____
how much _____, age started _____ age stopped _____

