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.
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: _____________________________

(#12851) (5/18)
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:

__________________________________________________________________________
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
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 ____________________________
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:

- Ankylosing Spondylitis: □ □ __________________________
- Autoimmune Disease: □ □ __________________________
- Gout: □ □ __________________________
- Lupus: □ □ __________________________
- Lyme Disease: □ □ __________________________
- Osteoarthritis: □ □ __________________________
- Pseudogout: □ □ __________________________
- Rheumatoid Arthritis: □ □ __________________________
- Congenital or Inherited
  Abnormality of Hand or Extremity: □ □ __________________________

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
Surgical History

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

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<thead>
<tr>
<th>Type</th>
<th>Where</th>
<th>Date</th>
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Orthopaedic Hardware: (i.e. hip or knee replacements, rods, screws or plates)

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<th>Type</th>
<th>Where</th>
<th>Date</th>
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Other Surgical History: (Please list all other surgical procedures)

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Medications

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

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<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
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Preferred Pharmacy: __________________________________________

Town: ____________________  Phone: ________________________
Allergies

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

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<th>Allergy</th>
<th>Reaction</th>
<th>Allergy</th>
<th>Reaction</th>
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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 ______