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: _______________________________
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:

You Family Member

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)

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: ____________________________
## Allergies

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

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
<th>Allergy</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## 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 ______