Dartmouth Health

Alice Peck Day Memorial Hospital

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

John Houde, MD
Alexandra Angelo, PA-C

Diane Riley, MD
Joel Dizon, PA-C

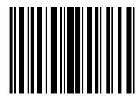
Ivan Tomek, MD
Rebecca Van Dolah, PA-C

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: _____________________________

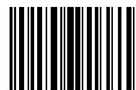
Secondary Insurance Name: ____

Address: _____________________________________ Phone#: ___________________________

ID # ____ Group #: __________________________

Subscriber Name: _____________________________ DOB: ______________________________

Date form complete ___________________________



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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

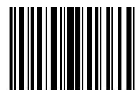
Have you filed a report of injury for this problem? ☐ yes ☐ no

Have you missed work because 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:

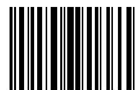
☐ X-rays Date ____________ Location ____________________

☐ 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:	☐	☐	______________________________
Autoimmune Disease:	☐	☐	______________________________
Gout:	☐	☐	______________________________
Lupus:	☐	☐	______________________________
Lyme Disease:	☐	☐	______________________________
Osteoarthritis:	☐	☐	______________________________
Pseudogout:	☐	☐	______________________________
Rheumatoid Arthritis:	☐	☐	______________________________
Congenital or Inherited Abnormality of Hand or Extremity:	☐	☐	______________________________

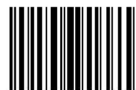
Other medical history: (Please list any other conditions that you have been diagnosed with)

____

____

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

Which is your dominant hand? ☐ Right ☐ Left



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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 ______________

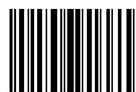
Medications

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 _______