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 complete__________________________
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?

________________________________________
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
<table>
<thead>
<tr>
<th>Type</th>
<th>Where</th>
<th>Date</th>
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<tbody>
<tr>
<td>Orthopaedic Hardware: (i.e. hip or knee replacements, rods, screws or plates)</td>
<td></td>
<td></td>
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<tr>
<td>Type</td>
<td>Where</td>
<td>Date</td>
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Other Surgical History: (Please list all other surgical procedures)

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<th>Type</th>
<th>Date</th>
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| Type | Date |

Medications

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

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<thead>
<tr>
<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:

<table>
<thead>
<tr>
<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 _____