LAKE CHELAN COMMUNITY HOSPITAL
HEALTHCARE CLOSE TO HOME

Orthopedic New Patient Form

M.I.S.T.
Methow Institute of Sports Traumatology

Date: __/__/__

Name _____ Age _____ Sex ____

Chief Complaint _____

Labor and Industry? ❒No ❒Yes

A. History of Present Illness

1. Date of onset / injury _____

2. Referred By: ❒Self ❒ Relative / Friend ❒PCP (MD/ Clinic Name) _____

3. What diagnostic test(s) have you had for this problem?

❒ Orthopedic ❒X-ray ❒MRI ❒CT ❒ Nerve Conduction ❒Labs ❒ Other _____

4. What treatments have you had?

❒Surgery ❒Steroid Injection ❒PT ❒Chiropractor ❒Massage ❒Bracing ❒NSAIDS ❒Narcotics ❒Other _____

5. Extremity Affected? ❒Right ❒ Left ❒Both

6. Which Location is bothering you?

❒Hand ❒Wrist ❒ Elbow ❒Shoulder ❒Foot ❒Ankle ❒Knee ❒Hip

Other _____

7. Describe you symptoms:

❒Pain ❒Weakness ❒Deformity ❒Instability ❒Numbness/ Tingling ❒Swelling

Other _____

8. What is the severity of your pain? ____ / 10 (1 is the least pain and 10 is the worst pain.)

9. How long have you been having these symptoms? (Please write down the number of days, weeks, months, or years) _____ ❒Days ❒Weeks ❒Months ❒Years

10. How often are your symptoms? ❒Constant ❒Intermittent ❒ Daily ❒ Occasionally ❒Rarely

11. How did your symptoms start? ❒ Trauma ❒ Gradual

B. Past Medical History

1. Please check all medical problems:

❒High Blood Pressure ❒ Stroke ❒Thyroid ❒Blood Clots ❒Arthritis ❒Osteoporosis ❒Asthma ❒Diabetes ❒High Cholesterol ❒Stomach Ulcer ❒Depression ❒Heart Disease ❒Cancer ❒Hepatitis C ❒COPD/ Emphysema ❒None

Other _____

2. Have you had any orthopedic surgery in the past? ❒No ❒Yes

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Others: _____

_____

3. Have you had any other surgical procedures?

Others: _____

_____

C. Family Medical History:

❒None ❒Arthritis ❒Blood Clots ❒Bone Disease ❒Heart Disease ❒Diabetes ❒Cancer

Other: _____

D. Social History:

1. Employment: ❒ Yes ❒No ❒Retired

2. Occupation: _____

3. Smoking / Tobacco use: ❒Current (__packs / day for __ years) ❒Quit(__packs / day for __ years) ❒Never

4. Exercise: ___ times / week

5. Drug use: ❒Yes ❒No

E. Review of Systems: (Please check if you currently have problems related to the following systems.)

1. Constitutional: ❒Denies ❒Fevers/Chills ❒Unintentional Weight Change ❒Other: _____

2. Skin: ❒Denies ❒Rash ❒Sores ❒Increased Bruising ❒Other: _____

3. Ears, Nose, Throat: ❒Denies ❒Sore Throat ❒Difficulty Swallowing ❒Dizziness ❒Other: _____

4. Gastrointestinal: ❒Denies ❒Abdominal Pain ❒Nausea/Vomiting ❒Other: _____

5. Genitourinary: ❒Denies ❒Incontinence ❒Painful Urination ❒Other: _____

6. Respiratory: ❒Denies ❒Shortness of Breath ❒Chronic Cough ❒Other: _____

7. Cardiovascular ❒Denies ❒Chest Pain ❒ Palpitations ❒ Leg Swelling ❒Other: _____

8. Musculoskeletal: ❒Denies ❒Joint Pain ❒Swollen Joint ❒Sore Muscles ❒Other: _____

9. Neurologic: ❒Denies ❒Numbness ❒Weakness ❒Other: _____

10. Hematologic: ❒Denies ❒Anemia ❒Increased Bleeding ❒Other: _____

F. Medications

1. Do you have any allergies? ❒No

❒Yes ❒Sulfa ❒Penicillin ❒Contrast Dye ❒Latex ❒Other: _____

2. Current Medications: ❒None

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____