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Medical History Update

Patient Name _____ Date _____ Date of Birth: _____

Sex: _____ Height: _____ Weight: _____ Handed R/L

Primary Care Physician: _____ May we send a letter to your physician? Y / N

Allergies: _____

What brings you to the office today?

Follow up from surgery (please specify type): _____

New / Follow up fracture (please specify type): _____

Follow up painful hip/knee/ankle/elbow/shoulder (please specify location and side):

Other: _____

Date of injury or surgery if applicable: _____

Is this work related? Y / N

Due to a motor vehicle accident? Y / N

Did you bring x-ray or MRI films with you? Y / N

What severity level would you use to describe your pain? (0-10 scale, 0= no pain, 10=worst pain) ____

Is there anything that makes the pain worse? _____

Is there anything that relieves the pain? _____

Please list any medications you have tried for this problem:

Have you tried any of the following?

Braces Cane/Walker Physical Therapy Steroid Injection Synvisc/Supartz/Euflexxa

Since your last visit:

Are you taking any new medications? Y / N Please List _____

Have you had any surgical procedures? Y / N Please List _____

Do you have any new medical conditions? Y / N Please List _____

Patient Signature _____