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

John Houde, MD | Diane Riley, MD | Leonard Rudolf, MD | Ivan Tomek, MD
Alexandra Angelo, PA-C | Joel Dizon, PA-C | Scott Mirick, PA-C | 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.

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

John Houde, MD | Diane Riley, MD | Leonard Rudolf, MD | Ivan Tomek, MD
Alexandra Angelo, PA-C | Joel Dizon, PA-C | Scott Mirick, PA-C | Rebecca Van Dolah, PA-C

## 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:** _____

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

John Houde, MD | Diane Riley, MD | Leonard Rudolf, MD | Ivan Tomek, MD
Alexandra Angelo, PA-C | Joel Dizon, PA-C | Scott Mirick, PA-C | Rebecca Van Dolah, PA-C

## 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?

_____

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

John Houde, MD | Diane Riley, MD | Leonard Rudolf, MD | Ivan Tomek, MD
Alexandra Angelo, PA-C | Joel Dizon, PA-C | Scott Mirick, PA-C | Rebecca Van Dolah, PA-C

## 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

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

John Houde, MD | Diane Riley, MD | Leonard Rudolf, MD | Ivan Tomek, MD
Alexandra Angelo, PA-C | Joel Dizon, PA-C | Scott Mirick, PA-C | Rebecca Van Dolah, PA-C

☐ **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 _____

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

John Houde, MD | Diane Riley, MD | Leonard Rudolf, MD | Ivan Tomek, MD
Alexandra Angelo, PA-C | Joel Dizon, PA-C | Scott Mirick, PA-C | Rebecca Van Dolah, PA-C

**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

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

John Houde, MD | Diane Riley, MD | Leonard Rudolf, MD | Ivan Tomek, MD
Alexandra Angelo, PA-C | Joel Dizon, PA-C | Scott Mirick, PA-C | Rebecca Van Dolah, PA-C

## 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: _____

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

John Houde, MD | Diane Riley, MD | Leonard Rudolf, MD | Ivan Tomek, MD
Alexandra Angelo, PA-C | Joel Dizon, PA-C | Scott Mirick, PA-C | Rebecca Van Dolah, PA-C

## 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 _____