New Dr. Warme Patient Form

UW Medicine

Eastside Specialty Center – Dr. Winston J Warme
1700 116th Ave NE / Bellevue, WA / 425-646-7777

Affix Pt Label Here

Name:
U Number:
DOB:

Name _____ Date _____ Age _____

How did you hear about us? _____

Requesting Physician

Name _____ **UPIN #** _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____ email _____

Primary Care Physician

Name _____ **UPIN #** _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____ email _____

Chief Complaint - Please describe the problem that brings you into the office today:

Social History

Tobacco Use

Mark Only One:	Packs per day:	Years:	Date quit:	Types:
☐ Never	☐ 0.5	☐ 5	_____	☐ Cigarettes
☐ Quit	☐ 1	☐ 10		☐ Pipe
☐ Passive	☐ 1.5	☐ 15		☐ Cigars
☐ Yes	☐ 2	☐ 20		☐ Snuff
	☐ _____	☐ _____		☐ Chew

Alcohol Use

☐ No
☐ Yes

Drinks per week:
#_____ Can(s) of beer
#_____ Drink(s) containing 0.5 oz of alcohol
#_____ Glass(es) of wine
#_____ Shot(s) of liquor

Drug use

☐ No
☐ Yes

Use per week:
☐ 1
☐ 2
☐ 5
☐ 10
☐ _____

IV drug use:
☐ No
☐ Yes

Are you currently working? ☐Yes ☐No What is or was your occupation? _____

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Family History

Please check if any of your **family members** have had the following:

☐ ADHD	☐ Colorectal cancer	☐ Lipids
☐ Alcohol/Drug	☐ Diabetes	☐ Osteoporosis
☐ Allergic/Atopic Disease	☐ Gastrointestinal (GI)	☐ Psych
☐ Arthritis	☐ Genitourinary (GU)	☐ Pulmonary
☐ Autoimmune	☐ Heart	☐ Stroke
☐ Cancer	☐ Hypertension	☐ Thyroid

Other _____

Past Medical History

1. Do you have, or are you being treated for, any of the following (please check all that apply):

☐ Allergic rhinitis (477.9)
☐ Anxiety (308.0)
☐ Asthma (493.90)
☐ Bipolar (296.8)
☐ Bleeding/clotting disorder (286.9)
☐ Cancer (CA) (234.9)
☐ Chemical dependency ☐ Drug (304.90)
☐ Alcohol (303.9)
☐ Chronic lung disease/emphysema (COPD) (496)
☐ Congestive heart failure (CHF) (428.0)
☐ Coronary artery disease (CAD) (414.00)
☐ Depression (311)
☐ Diabetes ☐ Using insulin (IDDM) (250.01)
☐ Not using insulin (NIDDM) (250.00)
☐ Fibromyalgia (729.1)
☐ Heartburn (787.1)
☐ Reflux (GERD) (530.81)
☐ Heart attack (MI) (410.9)
☐ Hepatitis ____ (please specify type(s)) (573.3)
☐ High blood pressure (HTN) (401.9)
☐ High cholesterol (272.4)
☐ Psoriasis (696.5)
☐ Rheumatoid Arthritis (RA) (714.0)
☐ Stroke (434.91)
☐ Transient ischemic attack (TIA) (435.9)
☐ Thyroid disorder ☐ Hypothyroidism (244.9)
☐ Hyperthryroidism (242.90)
☐ Sleep Apnea (780.57)
☐ Other Sleep disorder/trouble sleeping/(insomnia) (780.50)
☐ Ulcers ☐ Stomach ulcers (531)
☐ Peptic ulcer disease (PUD) (533)
☐ Other (specify)_____
_____
_____
_____
☐ **NO PAST MEDICAL HISTORY** (1000)

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Past Surgical History

1. What studies have you had for this problem? (Check all that apply)

☐ X-rays ☐ CT ☐ MRI ☐ Arthrogram ☐ Nerve Study (EMG) ☐ Bone Scan

☐ Other:_____

2. Have you had any previous **surgeries for this problem**? ☐Yes ☐No

Surgeries for This Problem and if they helped	**Surgeon**	**Year**

3. List all **Other Bone/Joint (Orthopedic) Surgeries**.

Surgeries	**Year**

Musculoskeletal	20999	Neck/Chest	21899
Arthroscopy	29909	Spine	22899
Shoulder	23929	Pelvis/Hip	27299
Upper Arm/Elbow	24999	Femur/Knee	27599
Forearm/Wrist	25999	Leg/Ankle	27899
Hand/Finger	26989	Foot/Toes	28899

4. Please list/check all **Other Surgeries** you have had.

Surgeries	**Year**
☐ **No previous surgeries** (100)	
☐ Appendix (appendectomy) (44950)	
☐ Gall bladder (cholecystectomy) (47600)	
☐ Bypass/open heart (CABG) (33999)	
☐ Hernia Repair (49585)	
☐ Hysterectomy (581550)	
☐ Tonsils removed (tonsillectomy) (42820)	

Other Surgeries	**Year**

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Allergies

1. Do you have any allergies? ☐Yes ☐No if so, please list

To **Medications?** _____

To **Foods?** _____

2. Are you allergic to **latex?** ☐Yes ☐No

3. Are you allergic to **iodine?** ☐Yes ☐No

Medications

1. Are you taking any pain medications ☐ YES ☐ NO If so, please list all:

Pain Medications	**Dose**	**Times per day**	**Reason for taking**

2. All other Medications	**Dose**	**Times per day**	**Reason for taking**

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Please Check one: ☐Right Handed ☐Left Handed ☐Ambidextrous

Is this a work related problem? ☐Yes ☐No

If yes, list your OWCP Claim# _____ or L&I Claim# _____

If disabled, when did you last work? _____

Is a lawyer involved with this problem? If so, name/address _____

_____

History of Present Illness

1. Location - where is the problem located?

☐ Right Side	☐ Shoulder	☐ Knee
☐ Left Side	☐ Elbow	☐ Ankle
☐ Both Sides	☐ Other _____	

2. **Severity** - Please rate the intensity of your joint Pain/discomfort: (1 = No Pain, 10 = Severe Pain)

1 2 3 4 5 6 7 8 9 10

3. Context - How did this problem begin? _____

_____

4. **Modifying Factors** -

What makes your symptom(s) worse?	What improves your symptom(s)?	
☐ Using affected side	☐ Rest	☐ _____
☐ Work	☐ Ice	
☐ Exercise	☐ Heat	
☐ Don't know	☐ Exercise	
☐ _____	☐ NSAIDs (anti-inflammatories)	

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Review of Systems
Do you have or had any of the following Problems?

	(Check any that apply)		Comments
General	☐weight gain ☐weight gain loss ☐fatigue	☐insomnia ☐fever ☐night-sweats/chills	
Eye	☐glasses/contacts ☐cataracts	☐glaucoma	
Ear/Nose/Throat	☐sinus trouble ☐hearing loss	☐ringing in ears	
Heart	☐irregular heartbeat ☐high blood pressure ☐chest pain	☐fluttering in chest ☐coronary disease	
Lung	☐shortness of breath ☐difficulty breathing	☐lung disease ☐persistent cough	
Stomach	☐decreased appetite ☐constipation ☐heartburn	☐nausea ☐diarrhea ☐hepatitis ☐A ☐B ☐C	
Muscles/ Bones	☐arthritis ☐fractures	☐sprains	
Urinary Tract	☐kidney stone ☐bladder/kidney infections	☐prostate problems ☐painful urinating	
Skin	☐masses ☐blisters	☐non-healing wounds ☐dermatitis	
Neurology	☐seizures ☐tingling	☐numbness ☐severe headaches	
Mental Health	☐anxiety ☐depression	☐other (please describe)	
Endocrine	☐increased thirst ☐diabetes	☐thyroid	
Blood/Lymph	☐bleeding or clotting problems ☐anemia ☐swollen or enlarged lymph nodes		
Immunological	☐hay fever ☐lupus	☐HIV/AIDS	

SANE Score

How would you rate your affected and opposite extremity today as a percentage of normal (0% to 100% scale with 100% being normal)?

Right Side:_____% Left Side:_____%

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Physician Signature_____ Date_____

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If you have a shoulder problem,
please fill out this Simple Shoulder Test
for BOTH of your shoulders.

Simple Shoulder Test

Please answer YES or NO for **BOTH** of your shoulders		RIGHT		LEFT		
		YES	NO	YES	NO	
1	Is your shoulder comfortable with your arm at rest by your side?	☐	☐	☐	☐	1
2	Does your shoulder allow you to sleep comfortably?	☐	☐	☐	☐	2
3	Can you reach the small of your back to tuck in your shirt with your hand?	☐	☐	☐	☐	3
4	Can you place your hand behind your head with the elbow straight out to the side?	☐	☐	☐	☐	4
5	Can you place a coin on a shelf at the level of your shoulder without bending your elbow?	☐	☐	☐	☐	5
6	Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?	☐	☐	☐	☐	6
7	Can you lift eight pounds (a full gallon container) to the level of your shoulder without bending your elbow?	☐	☐	☐	☐	7
8	Can you carry twenty pounds at your side with this extremity?	☐	☐	☐	☐	8
9	Do you think you can toss a softball under-hand twenty yards with this extremity?	☐	☐	☐	☐	9
10	Do you think you can toss a softball over-hand twenty yards with this extremity?	☐	☐	☐	☐	10
11	Can you wash the back of your opposite shoulder with this extremity?	☐	☐	☐	☐	11
12	Would your shoulder allow you to work full-time at your regular job?	☐	☐	☐	☐	12

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If you have an elbow problem,
please fill out this Elbow Shoulder Test
for BOTH of your elbows.

Simple Elbow Test

	Please answer YES or NO for **BOTH** of your elbows	**RIGHT** YES	**RIGHT** NO	**LEFT** YES	**LEFT** NO	
1	Is your elbow comfortable with your arm at rest by your side?	☐	☐	☐	☐	1
2	Does your elbow allow you to sleep comfortably?	☐	☐	☐	☐	2
3	Does your elbow allow you to reach the small of your back to tuck your shirt in?	☐	☐	☐	☐	3
4	Can you place your hand behind your head with the elbow straight out to the side?	☐	☐	☐	☐	4
5	Will your elbow allow you to pull on socks or stockings?	☐	☐	☐	☐	5
6	Does your elbow allow you to lift one pound to the level of your shoulder?	☐	☐	☐	☐	6
7	Can you use your arm to help you rise from a chair?	☐	☐	☐	☐	7
8	Will your elbow allow you to carry 20 pounds at your side?	☐	☐	☐	☐	8
9	Will your elbow allow you to comb your hair?	☐	☐	☐	☐	9
10	Will your elbow allow you to throw a ball with this arm?	☐	☐	☐	☐	10
11	Will your elbow allow you to wash the back of your opposite shoulder?	☐	☐	☐	☐	11
12	Would your elbow allow you to work full-time at your regular job?	☐	☐	☐	☐	12

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