MASSACHUSETTS GENERAL HOSPITAL
ORTHOPAEDICS

Thomas F. Holovacs, MD

Department of Orthopedics
55 Fruit Street, Suite 3200-3G
Boston, Massachusetts 02114

NEW PATIENT PAPERWORK

Prior to your visit please register at https://patientgateway.partners.org/public/

Name:____MGH #:_______________________________
DOB: ______________ AGE: ______________
Telephone: (Home) _______________ (Work)_________________________ (Cell)_____________
Email:____
Referral source: ____

Occupation: ____

SHOULDER INFO

Problem Shoulder: ❑ Right ❑ Left

Dominant Side: ❑ Right ❑ Left

Date of Injury: __________________

Prior Treatment: ❑ Yes ❑ No

Mechanism of Injury: ____
____
____

Current Chief Complaint: ❑ Pain ❑ Stiffness ❑ Weakness ❑ Instability

Physical therapy? ❑ Yes ❑ No

Cortisone injection in your shoulder? ❑ Yes ❑ No

Previous shoulder surgery? ❑ Yes ❑ No (if yes, please detail below)
____
____
____

Level of pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

If 100% is a perfect shoulder (no pain and great strength) and 0% is a useless shoulder please tell us what percentage (%) would you rate your shoulder? ________________________

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PAST MEDICAL HISTORY

Please indicate if you have ever been diagnosed with the following:

❑ HTN
❑ Heart attack
❑ Sleep apnea
❑ Asthma
❑ COPD
❑ Blood clots
❑ Anemia
❑ Heart valve
❑ Stent(s)
❑ GERD
❑ Diabetes
❑ Seizures
❑ Stroke

❑ Other significant medical conditions: ____

Allergies:
____
____
____
____
____

Height ______ Weight ______

Do you smoke cigarettes: ❑ Yes ❑ No How much?___________________________

Do you drink alcohol? ❑ Yes ❑ No How much?___________________________

Have you ever been exposed to AIDS or hepatitis? ❑ Yes ❑ No

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REVIEW OF SYSTEMS

Check all that apply to your health

Constitutional
- ❑ Fever, Chills, Sweats
- ❑ Weight loss
- ❑ Change in appetite
- ❑ Excessive fatigue

Eyes, Ears, Nose, & Throat
- ❑ Recent changes in vision
- ❑ Glaucoma
- ❑ Metal fragments in eyes
- ❑ Nosebleeds
- ❑ Hearing loss
- ❑ Poor balance

Cardiovascular
- ❑ Irregular pulse
- ❑ Chest pain or Angina
- ❑ Elevated Cholesterol
- ❑ Heart murmur
- ❑ Calf pain when walking

Respiratory
- ❑ Lung cancer
- ❑ Asthma, wheezing
- ❑ Blood in sputum
- ❑ Chronic cough
- ❑ Pneumonia or bronchitis

Gastrointestinal
- ❑ Ulcers or gastritis
- ❑ Nausea or vomiting
- ❑ Jaundice or liver problem
- ❑ Gallbladder problem
- ❑ Colon cancer
- ❑ Blood in stool

Genitourinary
- ❑ Bladder infections
- ❑ Blood in urine
- ❑ Difficulty with urination
- ❑ Kidney stones
- ❑ Prostate problems

Musculoskeletal
- ❑ Swelling in multiple joints
- ❑ Excessive flexibility of joints
- ❑ Broken bones, which? _______
- ❑ Dislocated joints, which? _____
- ❑ Fibromyalgia
- ❑ Reflex Sympathetic Dystrophy

Skin
- ❑ Chronic rashes
- ❑ Eczema or Psoriasis
- ❑ Skin cancer
- ❑ Breast lump/nipple discharge

Neurological
- ❑ Loss of memory
- ❑ Leg pain/sciatica
- ❑ Weakness of a limb
- ❑ Numbness of a limb
- ❑ Loss of sensation of a limb
- ❑ Bowel/bladder control loss

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Claustrophobia

Endocrine
- ❑ Thyroid problems
- ❑ Hormone Replacement Therapy
- ❑ Taken Prednisone

My Physician: I authorize Thomas F. Holovacs, MD or his agents to obtain my medical records from other physicians or parties. A photocopy of this form may be used in lieu of the original.

My Insurance carriers: I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physician(s). I agree that this authorization will cover all medical services until revoked by me. I agree that a photocopy of this form may be used in place of the original. I understand that I am responsible for the charges that occur as a result of my medical treatment.

____ ____________________

Signed (patient or responsible party) Date