OrthoVirginia
West End Orthopaedic Clinic

PATIENT HISTORY FORM

Patient Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Name of Primary Care/Family Physician: _____

CHIEF COMPLAINT: What are you seeing the doctor for today?

_____

Have you been treated by another physician/hospital for this problem? ( ) No ( ) Yes

Is this an injury? ( ) Yes / date _____ ( ) No / approximate onset :_____

Is the problem you wish to be treated for today the result of:
( ) Car / motor-vehicle accident ( ) Work Accident ( ) Other type accident (fall; cut; etc)

If your accident did not occur in Virginia, please list the state: _____

Allergies: ☐ No known drug allergies ☐ I am allergic/sensitive to Latex products ☐ Contrast Dye

Please list all known medication allergies and reactions:

Allergy To	Reaction	Allergy To	Reaction

Medications: (Please list all medications you take **with or without a prescription)**(use additional paper)

Medication Name	Dosage/ # per day	Reason for taking	Side effects

Past Medical History:

Please check the box if you have, or have had, any of these medical conditions ( ) No Past Medical Problems

☐ Anemia
☐ Arthritis
☐ Osteoarthritis ☐ Rheumatoid Arthritis
☐ Asthma
☐ Atrial fibrillation/ erratic heartbeat
☐ Birth Defects
☐ Bladder Problems
☐ Blood Clots in the lung(s)
☐ Blood Clots in the leg(s)
☐ Blood Pressure, low
☐ Blood Pressure, high
☐ Blood Transfusion, previous
☐ Bowel Problems
☐ Cancer: Where: _____
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Diabetes
☐ Epilepsy/Seizures
☐ Gout,acute
☐ Hemophilia (excessive or easy bleeding)
☐ Hepatitis (A,B,C) (circle)
☐ HIV or AIDS
☐ Kidney/Renal Disease
☐ Lung Problems
☐ MRSA
☐ Psychological Disorder
☐ Recurrent Infection
☐ Sexually Transmitted Disease
☐ Stroke (CVA,TIA)
☐ Thyroid Disease
☐ Ulcer
☐ Other: please explain:
_____

_____

OVER →

Surgical History:

☐ I DO NOT have a history of any previous surgeries (Please skip to Family History)

Have you had surgery in the past 12 months: ☐ No ☐ Yes, hospital _____

Did you have any trouble with your surgery/anesthesia: ☐ No ☐ Yes – describe below:

List of previous surgery/hospitalizations includes:

Type of Surgery/Hospitalization	When	Where was surgery	Surgeon

Family History:

Have your mother, father, grandparents, brothers or sisters been treated in the past or are they currently receiving treatment for any of the following conditions:

☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Hypertension ☐ Kidney Disease
☐ Stroke ☐ Tuberculosis ☐ Other: _____

Please list cause of death or health status for the following family members:

Mother: _____ Father: _____

Social History:

Marital Status: ( ) Single ( ) Married ( ) Divorced/Separated ( ) Widowed

☐ Employed – occupation: _____ ☐ Work in home ☐ Student ☐ Retired

Do you have children? ☐ No ☐ Yes-number ____ Do you live alone? ☐ No ☐ Yes

Smoking Status: ( ) Never Smoked ( ) Former Smoker ( ) Current Smoker _____ packs per day for ____ years

Do you consume alcoholic beverages? ☐ No ☐ Yes – number of drinks per week: _____

Review of Systems:

Please describe anything you are **currently** experiencing – or mark NORMAL for the section
If all systems are normal please check this box: ☐ (No problems noted for any body system)

It will be assumed that all systems are normal if no boxes are checked.

	Normal	Problem Details:		Normal	Problem Details:
Musculoskeletal	☐	_____	Stomach	☐	_____
General health	☐	_____	Bladder	☐	_____
Eyes	☐	_____	Blood	☐	_____
Ears/Nose/Throat	☐	_____	Neurological	☐	_____
Thyroid	☐	_____	Psychiatric	☐	_____
Breathing	☐	_____	Skin	☐	_____
Heart	☐	_____	Allergic	☐	_____

FEMALE REPRODUCTIVE: Are you or could you be pregnant? ☐ No ☐ Yes

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____