FREDERICKSBURG ORTHOPAEDIC ASSOCIATES, PC (FOA)
Patient Medical History Form

Account # ____________________

Patient's Full Name: ____ Date: _______________

Marital Status: ☐ Married ☐ Divorced ☐Widowed ☐ Single Handedness: ☐ Right ☐ Left ☐ Ambidextrous

Gender: ☐ Male ☐ Female Height: ____ft. ____in. Weight:________

** Female Patients: Is there any chance you could be pregnant? ☐ Yes ☐ No

MEDICAL HISTORY

Check any of the medical problems that you have had. Indicate if the problem is current (even if it is being treated) or resolved:

☐ NONE
☐ Anxiety/Depression
☐ Arthritis (Where?): __________________
☐ Asthma
☐ Bleeding Problems
☐ Blood Clot (DVT)Where?______________
☐ Cancer (Where?):____________________
☐ COPD/Emphysema/Lung Disease
☐ Coronary Artery Disease
☐ Diabetes Adult Onset/Juvenile
☐ Heart attack
☐ Hepatitis A/B/C
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV Positive
☐ Immune Disorder
☐ Kidney Disease
☐ Liver Disease
☐ Osteoporosis
☐ Overweight
☐ Peripheral Vascular Disease
☐ Psychiatric Disorder (specify):______
____
☐ Seizure Disorder
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ Other (Specify): ___________________

SURGICAL HISTORY

Check any surgeries listed below you have had and please indicate the year of the surgery:

☐ NONE
☐ Appendectomy _________________________________
☐ Back - spine surgery_____________________________
☐ By-pass/open heart ______________________________
☐ Cataract extraction ______________________________
☐ Cesarean Delivery ______________________________
☐ Gall bladder ___________________________________
☐ Hernia repair __________________________________
☐ Hip Replacement Left / Right ____________________
☐ Hysterectomy __________________________________
☐ Knee Arthroscopy Left /Right ____________________
☐ Knee Replacement Left /Right _________________
☐ Mastectomy Left / Right _______________________
☐ Neck - spine surgery __________________________
☐ Prostate surgery _____________________________
☐ Thyroid surgery______________________________
☐ Tonsillectomy _______________________________
☐ Other (Specify): ______________________________
☐ Other (Specify): ______________________________
☐ Other (Specify): ______________________________
☐ Other (Specify): ______________________________

ALLERGIES

Check anything listed below to which you are allergic and please indicate your reaction:

☐ NONE
☐ Adhesive Tape __________________
☐ Anti-inflammatories ______________
☐ Codeine _______________________
☐ Erythromycin ___________________
☐ Iodinated contrast _______________
☐ Iodine/Betadine __________
☐ Latex ___________________
☐ Morphine ________________
☐ Penicillin ________________
☐ Radiographic Dyes ________
☐ Sulfa ______________________________
☐ Tetracycline _________________________
☐ Other (Specify): _____________________
☐ Other (Specify): _____________________
☐ Other (Specify): _____________________

MEDICATIONS

What medications are you currently taking? Please include both prescription and non-prescription.

Medication	Dose	# Times a Day

FAMILY HISTORY

Has anyone in your immediate family ever had any of the following? Please check all that apply and indicate the family member: M=mother, F=father, B=brother, S=sister.

☐ NONE
☐ Unknown
☐ Alcohol/Substance Abuse_________________
☐ Asthma _________________________________
☐ Bleeding disorder _______________________
☐ Blood clots / Pulmonary embolism _______
☐ Cancer:__________________________________
☐ Colitis __________________________________
☐ Coronary artery disease __________________
☐ Diabetes _________________
☐ Heart Attack ______________
☐ High blood pressure _______
☐ High cholesterol __________
☐ Hypothyroidism __________
☐ Leukemia ________________
☐ Osteoarthritis _____________
☐ Osteoporosis ______________
☐ Rheumatic fever _________________
☐ Rheumatoid arthritis ____________
☐ Seizure disorder _________________
☐ Stroke _________________________
☐ Tuberculosis ____________________
☐ Other (Specify): _________________
☐ Other (Specify): _________________
☐ Other (Specify): _________________

SOCIAL HISTORY:

How much alcohol do you consume?

☐ I do not drink alcohol ☐ I consume ______ drinks a day ☐ I consume ______ drinks a week

Do you currently smoke?

☐ I have never smoked ☐ Former smoker, quit ______ ☐ Yes, I smoke _____ packs per day for ______years

What is your current occupation?

☐ Student
☐ Housewife/Homemaker
☐ Retired - from what occupation? ____________________________________ Since when? ______________________
☐ Employed - ____ Full time or ___ Part time as ____
☐ Currently an unemployed ____
☐ On disability - ___Permanent or ___ Partial since (date) ___________________ due to ________________________

With whom do you live?

☐ Alone
☐ With family
☐ With friends

REVIEW OF SYSTEMS

Have you recently experienced any of the following? Please check all that apply.

GENERAL:	**GI:**	**HEART:**	**MUSCULOSKELETAL:**
Weight gain	Nausea	Chest pain	Muscle weakness
Weight loss	Vomiting	Palpitations	Stiffness
Fever	Change in bowel habits		Joint pain
Chills			Joint redness
Night sweats			
RESPIRATORY:	**GU:**	**SKIN:**	**NEUROVASCULAR:**
Shortness of breath	Frequent urination	Change in moles	Swelling in lower extremities
Coughing/wheezing	Blood in urine	Skin changes	Emboli (Blood clots)
Chronic cough	Difficulty w/ urination	Breast lumps	Dizziness
Sleep apnea			Fainting
EYES:	**ENT:**	**HEMATOLOGY:**	☐ **None**
Loss of vision	Hearing loss	Abnormal bleeding	
Double vision	Nose bleeds		

If you have checked any of the above, are you under the care of a primary care physician, or other specialist such as a cardiologist or pulmonologist whom is aware of the issues you have been experiencing? ☐ Yes ☐ No

We advise that if you experience, or have been experiencing, a new onset of any of the above that you notify your primary care physician as soon as possible.

Everything that I have answered is true and correct to the best of my knowledge.

____ Date: _____/_____/____________

Patient Signature