FREDERICKSBURG ORTHOPAEDIC ASSOCIATES, PC
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ORTHOPAEDICS
JOINT • SPINE • SPORTS • HAND • TRAUMA

New Patient Medical History Form

Account #_____ Date: _____

Patient's Full Name: _____ DOB: _____

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
☐ Rheumatoid
☐ Osteoarthritis Which Joints?_____
☐ Asthma
☐ Blood Clotting Disease
☐ 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
☐ Pulmonary Embolism
☐ Obesity
☐ 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 <u>please indicate the year of the surgery</u>:

☐ 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_____
☐ Cardiac Catheterization _____
☐ Cardiac Defibrillator _____
☐ Knee Replacement Left /Right _____
☐ Mastectomy Left / Right _____
☐ Neck - spine surgery_____
☐ Prostate surgery _____
☐ Thyroid surgery_____
☐ Tonsillectomy _____
☐ Fracture Surgery (body part): _____
☐ Other (Specify) _____
☐ 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_____ ☐ Iodine/Betadine_____ ☐ Sulfa_____

☐ Anti-inflammatories_____ ☐ Latex_____ ☐ Tetracycline _____

☐ Codeine_____ ☐ Morphine_____ ☐ Other (Specify): _____

☐ Erythromycin _____ ☐ Penicillin_____ ☐ Other (Specify): _____

☐ Iodinated contrast _____ ☐ Radiographic Dyes _____ ☐ Other (Specify): _____

☐ If penicillin allergic, have you ever taken the antibiotic Keflex? ☐ **Yes** ☐ **No**

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 _____ ☐ Diabetes _____ ☐ Rheumatic fever _____

☐ Alcohol/Substance Abuse _____ ☐ Heart Attack_____ ☐ Rheumatoid arthritis _____

☐ Asthma _____ ☐ High blood pressure_____ ☐ Seizure disorder _____

☐ Blood Clot_____ ☐ High cholesterol_____ ☐ Stroke _____

☐ Blood clots / Pulmonary embolism _____ ☐ Hypothyroidism _____ ☐ Tuberculosis _____

☐ Cancer: _____ ☐ Leukemia _____ ☐ Other (Specify): _____

☐ Colitis _____ ☐ Osteoarthritis_____ ☐ Other (Specify): _____

☐ Coronary artery disease _____ ☐ Osteoporosis_____ ☐ Other (Specify): _____

☐ Malignant Hyperthermia _____

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 circle all that apply.

GENERAL:
Weight gain
Weight loss
Fever
Chills
Night sweats

GI:
Nausea
Vomiting
Change in bowel habits

HEART:
Chest pain
Palpitations
Swelling in lower extremities

MUSCULOSKELETAL:
Muscle weakness
Stiffness
Joint pain
Joint redness

RESPIRATORY:
Shortness of breath
Coughing/wheezing
Chronic cough

GU:
Frequent urination
Blood in urine
Difficulty w/ urination

SKIN:
Change in moles
Skin changes
Breast lumps

NEUROVASCULAR:
Dizziness
Fainting

EYES:
Loss of vision
Double vision

ENT:
Hearing loss
Nose bleeds
Sleep apnea

HEMATOLOGY:
Abnormal bleeding
Emboli (Blood clots)

☐ **None**

If you have circled 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