ATLANTIC ORTHOPAEDIC SPECIALISTS

Leaders in Orthopaedic Health

PATIENT MEDICAL HISTORY

Date _____

Chart # _____

PC _____

Patient's Name _____ Ref. Physician: _____

Date of Birth _____ Age _____ Weight _____ Height _____ Blood Pressure if known _____

Problems with Anesthesia? ☐ YES ☐ NO If yes, explain _____

Current Complaints _____ Date of Last Tetanus _____

Allergies / Difficulties with Medication & Reaction ☐ None ☐ Latex ☐ Metal /Jewelry	Current Medication	How Taken ☐ None

Are you: ☐ Right handed ☐ Left handed

PERSONAL INFORMATION

☐ No Illnesses	☐ Common Cold	☐ Mental / Nervous Disorder	☐ Stroke
☐ AIDS / HIV	☐ Diabetes	(Specify) _____	☐ Tendonitis
☐ Angina	☐ Emphysema	☐ Pancreatitis	☐ Tuberculosis
☐ Asthma	☐ Gallbladder Disease	☐ Pneumonia	☐ Ulcers
☐ Arthritis	☐ Heart Attack	☐ Psoriasis	☐ Varicose Veins
☐ Bladder / Kidney Infection	☐ Heart Disease	☐ Raynaud's Disease	☐ Venereal Disease
☐ Bleeding Disorders	☐ Heart Murmur / Valve Problem	☐ Scarlet Fever	☐ Other:
☐ Bronchitis	☐ Hepatitis	☐ Seizures	☐ _____
☐ Bursitis	☐ High Blood Pressure	☐ Sinusitis	☐ _____
☐ Cancer	☐ Intestinal Problems	☐ Sleep Apnea	☐ _____

SOCIAL HISTORY

Do you smoke tobacco products? ☐ Yes, _____ pack(s) per day ☐ NO (Please choose one of the following below)
☐ I would like to quit ☐ Never smoked ☐ Former smoker

Do you drink alcohol? ☐ YES ☐ NO Number of drinks per day? _____ per week? _____

Do you take drugs? ☐ YES ☐ NO Check all that apply: ☐ Marijuana ☐ Cocaine ☐ Others (Specify)
_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Number of Children _____

Employment: (Type) _____

FAMILY HISTORY (Siblings, parents and children)

☐ No Diseases	☐ High Blood Pressure	☐ Other (specify)
☐ Asthma	☐ Kidney Disease	_____
☐ Arthritis	☐ Problems with Anesthesia	
☐ Cancer	☐ Seizures	_____
☐ Diabetes	☐ Stroke	
☐ Excessive Bleeding	☐ Tuberculosis	_____
☐ Heart Disease		

PHARMACY

Name
_____
Location
_____
Alternate Name
_____
Location
_____

Physician's Signature _____ Therapist's Signature _____

Previous Surgery: ☐ None Dates

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

RECENT DIAGNOSTIC TESTS (Please check all that apply within the last 3-6 months): ☐ None

☐ Chest X-ray ☐ Stress Test ☐ Blood Work ☐ EKG

REVIEW OF SYMPTOMS (Please check all that apply within the last 3-6 months)

General: ☐ None
☐ Fever
☐ Chills
☐ Night Sweats
☐ Weight Change

Gastrointestinal: ☐ None
☐ Nausea
☐ Vomiting
☐ Pain / Difficulty Swallowing
☐ Gas
☐ Indigestion
☐ Abdominal Pain
☐ Bloating
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids
☐ Bloody Stools

Musculoskeletal: ☐ None
☐ Fracture
☐ Sprain
☐ Strains
☐ Dislocations
☐ Joint Stiffness
☐ Joint Pain
☐ Joint Swelling
☐ Back Pain

Head: ☐ None
☐ Headaches
☐ Blackouts
☐ Seizures
☐ Dizziness

Heent: ☐ None
☐ Hearing Loss
☐ Double Vision
☐ Blurred Vision
☐ Ringing in Ears
☐ Post Nasal Drip
☐ Sore Throat
☐ Hoarseness

Genitourinary: ☐ None
☐ Blood in Urine
☐ Burning with Urination
☐ Bladder / Kidney Infections
☐ Frequency Urination
☐ Difficulty Starting Urination
☐ Sense of Full Bladder
☐ Urine Leaking
☐ Getting Up / Urinating at Night

Skin: ☐ None
☐ Rash
☐ Itching
☐ Change / Bleeding Mole

Respiratory: ☐ None
☐ Cough
☐ Sputum
☐ Coughing up Blood
☐ Wheezing

Cardiovascular: ☐ None
☐ Shortness of Breath
☐ Chest Pain
☐ Palpitation
☐ Heart Murmur
☐ Swelling of Feet
☐ Night Cramps

FEMALE PATIENTS

Do you take Birth Control Pills? ☐ YES ☐ NO If yes, type? _____

Do you take PREMARIN or ESTROGEN or other hormonal replacement? ☐ YES ☐ NO If yes, type? _____

Is there any chance you are pregnant? ☐ YES ☐ NO

I certify that above information is accurate and complete to the best of my knowledge. I will not hold Vann-Virginia Center for Orthopaedics, P.C., its physicians or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____