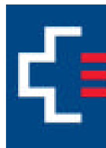

INOVA™ ORTHOPAEDICS AND SPORTS MEDICINE

New Patient History Form

Patient Label

*Date:*______________

*Name:*____*DOB:*___________________

Age _____ Ht ______ Wt _______ Occupation _________________________________

Are You? Right Handed? Left Handed?

CHIEF ORTHOPEDIC COMPLAINT Explain why you are here, include body part, symptoms, etc…

____
____
____

Date of Onset or Injury _________________________________

Did this injury occur at work? Yes No

Past Treatment for this injury (Include all dates, physicians and treatments)

____
____
____

PAST MEDICAL HISTORY

What illnesses and conditions are you currently under treatment for or have been in the past? (eg. Heart disease, diabetes, blood pressure)

Diabetes______________________ High Blood Pressure ________________________
Asthma ___________________ Cancer ___________________________________
Heart Trouble __________________Blood Disease______________________________
Kidney Trouble _________________Lung ____________________________________
Liver Trouble __________________ Psychiatric Disease _________________________
High Blood Pressure_____________ Sickle Cell Anemia _________________________
Other____

PATIENT LABEL

PREVIOUS HOSPITALIZATIONS (not including operations)

1.____
2.____
3.____
4.____
5.____

PREVIOUS OPERATIONS

1.____
2.____
3.____
4.____
5.____

CURRENT MEDICATIONS List all the medications you are now taking, including aspirin, pain meds, hormones, nerve, sleeping pills, vitamins, and over the counter meds.

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____

ALLERGIES Please list medications/drugs that you are allergic to and your reaction.

1.______________________ 4.______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

Do you smoke? Yes No Cigarettes Cigar Pipe
Do you chew tobacco/dip? Yes No
Amount per day? # of Years:
Have you quit? Yes No If so, how long?
Do you drink alcohol? Yes No How often?
Recreational drugs? Yes No Type/Frequency

PATIENT LABEL

FAMILY HEALTH

Have any blood relatives ever had any of the following? If so, indicate their relationship to you. (e.g. Diabetes – maternal grandmother)

____

____

____

REVIEW OF SYSTEMS: Please circle any health problems in the following areas.

HEART	MUSCULOSKELETAL	RESPIRATORY	ENDOCRINE
Coronary Artery Disease Hypertension High Cholesterol Heart Murmur Heart Failure Heart Attack Other	Osteoarthritis Osteoporosis Chronic Muscle Pain Swollen Joints RA Fibromyalgia Other	Asthma Emphysema Sleep Apnea Shortness of Breath Other	Thyroid Disease Diabetes Excessive Weight Loss Excessive Weight Gain Other
NEURO	**VASCULAR**	**HEENT**	**URINARY**
Numbness Seizure Disorder Tremors Stroke Other	Phlebitis Clotting / Bleeding Easy Bruising Anemia Other	Blurry Vision Hearing Loss Pain with Swallowing Other	Burning Blood in Urine Frequency Other
SKIN	**GASTROINTESTINAL**	**PSYCHIATRIC**	**GENERAL**
Rash Psoriasis Lesions Moles Other	Reflux Peptic Ulcer Hepatitis Gallstones Other	Anxiety Depression Schizophrenia ADHD Other	Cancer Fever Night sweats TB Chills Other_______________
GENITALS / BREAST Tumor Erectile Dysfunction Large Prostate Menopause Breast Cancer			
Other complaints:			
Is there any chance that you may be pregnant? Yes No N/A			
PHYSICIAN USE ONLY *All Systems Normal*			

Name of your primary care or family doctor? ___________________________________

Who referred you to this office? ____

Patient Signature: _______________________________

Date: / /