

# Winchester Orthopaedic Associates, Ltd.

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## PATIENT HISTORY

You will be asked to update your health status on a yearly basis. This information is collected to assist our patient care team in providing the best orthopaedic care possible. Please bring this form with you or mail at least three business days prior to your first visit. On your first visit we will need to make a copy of any **Insurance Cards** you have. We do not treat any patient under the age of 18 without the consent of a parent or legal guardian. **Parent or guardian** must be present at the time of appointment. Effective April 14, 2003 all patients are offered written material on how medical information about them may be used or disclosed.

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

The physician you are scheduled to see: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

**Please describe in detail the reason for your visit; identify side (left or right) and/or body parts:** \_\_\_\_\_

What activities do you have trouble with?: \_\_\_\_\_

How long have you had these symptoms?: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Who is your regular Medical Doctor? \_\_\_\_\_ Address: \_\_\_\_\_

**Who referred you to our practice?** \_\_\_\_\_

Dr. \_\_\_\_\_ first treated you for this injury on \_\_\_\_\_  In Office  E.R.  Urgent Care  Other: \_\_\_\_\_

Do you have Advance Directives?  Yes  No With which physician/facility?: \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Are you working now or going to school?  Yes  No When did you last work or go to school? Date: \_\_\_\_\_

Employer / School: \_\_\_\_\_ Phone: \_\_\_\_\_

Is there legal action pending related to this injury?  Yes  No

Has an attorney suggested you seek care for this injury?  Yes  No

### Workers Compensation

Were you injured at work?  Yes  No Date: \_\_\_\_\_

Describe how you were injured: \_\_\_\_\_

Employer (at time of accident): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Dates of employment: From \_\_\_\_\_ to \_\_\_\_\_

Occupation at time of accident: \_\_\_\_\_

Did you complete a written report of your injury with your employer?  Yes  No Date: \_\_\_\_\_

To whom did you report your injury? Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_

What is your Worker's Compensation Claim No.?: \_\_\_\_\_

Is there legal action pending on your work related injury?  Yes  No  N/A

### Motor Vehicle Accident

Were you involved in a motor vehicle accident?  Yes  No State: \_\_\_\_\_ Date: \_\_\_\_\_

Is there legal action pending on the motor vehicle accident?  Yes  No  N/A

Allergies to medicine: \_\_\_\_\_

Allergy to:  Soy  Eggs  Iodine  Shellfish  Radiologic Dyes  Metal Type: \_\_\_\_\_

Allergy to Latex?  Yes  No If yes, confirmed by Medical Doctor: \_\_\_\_\_

Allergies to food: \_\_\_\_\_

Other allergies: \_\_\_\_\_

I am:  Right Handed  Left Handed or  Both

**List medications that you take on a regular basis**

<i>Medication</i>	<i>Strength &amp; how often do you take</i>	<i>Who prescribed</i>

Do you currently take or have you taken over the counter medications:

- Aspirin     Advil     Aleve     Herbals     Glucosamine/Chondroitin     Vitamins

When? \_\_\_\_\_

Do you currently take or have you taken:

- Steroids     Coumadin     Plavix     Lovenox

When? \_\_\_\_\_

**Past Medical Testing**

<b>Tests</b>	<b>Yes</b>	<b>No</b>	<b>Location</b>	<b>Date</b>
EKG				
Cat Scan CT				
MRI				
EMG/Nerve Conduction Studies				
Myelogram				
Injections				
Arteriogram				
X-Rays				
Bone Scan				
Bone Density				
Hepatitis				
HIV				
Other Communicable Diseases				
Pregnancy Testing				

Place Patient Label Here

# Past Medical History

We would like to know more about you and your family's general health and medical history. Please check medical history for both you and your family members.

	You	Blood Relative
High Blood Pressure		
Diabetes		
I take insulin		
I take pills		
I control my diabetes with diet only		
Emphysema		
Tuberculosis		
Asthma		
Bronchitis		
Chronic Sinusitis		
Pneumonia		
Blood Clots		
Blood Thinner Medication		
Anemic		
Sickle Cell Anemia		
Heart Disease		
Heart Attack		
Congestive Heart Failure		
Heart Valve		
Stroke		
Stent		
Pacemaker		
Defibrillator		
Vascular Disease in the Legs		
Vascular Disease in the Arms		
Gum Infection/Disease		
Hepatitis		
Pancreatitis		
Colitis		
Diverticulitis		
Hiatal Hernia		
Gastric Reflux		
Gastric Ulcer		
Kidney Infection		
Thyroid Disease		
Arthritis		
Rheumatoid		
Other Inflammatory		
From Old Injury		
Cancer		
Type:		
Treatment:		
Surgery:		
Physician:		
Date:		
Nervous Break Down		
Depression		
Alcohol Dependency		
Treated for Psychiatric Illness/Disorder		
Treated for alcohol dependency		
Treated for drug dependency		

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ B.P.: \_\_\_\_\_

# Sleep Disturbance Evaluation

Please use this scale to rate the activities below:

- 0 = Never fall asleep                      1 = Occasionally fall asleep  
 2 = Frequently fall asleep                3 = Always fall asleep

- Sitting and Reading \_\_\_\_\_  
 Watching TV \_\_\_\_\_  
 Sitting inactive in a public place \_\_\_\_\_  
 As a passenger in a car for an hour without a break \_\_\_\_\_  
 Lying down to rest in the afternoon \_\_\_\_\_  
 Sitting and talking to someone \_\_\_\_\_  
 Sitting quietly after lunch without alcohol \_\_\_\_\_  
 In a car while stopped for a few minutes \_\_\_\_\_  
**TOTAL** \_\_\_\_\_

With a score of 11 or more, your physician may recommend Sleep Studies.

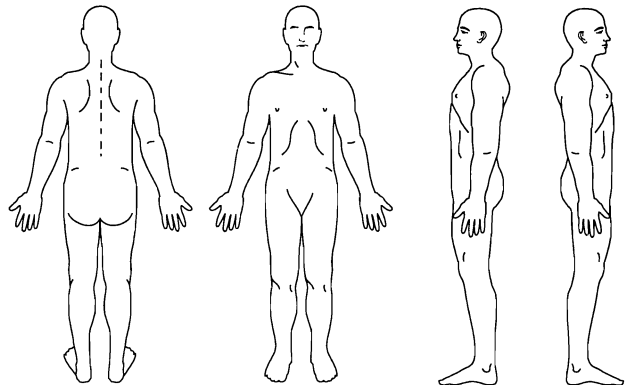
# Surgeries and Procedures

Please list all surgeries and or medical procedures, dates beginning with most recent.

Date	Procedure and side	Doctor

- I have had problems with Anesthesia             Yes    No  
 I have had Blood Transfusions                     Yes    No  
 I have had a reaction to Blood Transfusions/  
 Blood Products     Yes    No  
 Have you had an infection following Surgery?  Yes    No  
 When? \_\_\_\_\_  
 Have you been diagnosed with MRSA or VRE?  Yes    No

Using the key below, please describe your pain



When did you first notice your pain? \_\_\_\_\_

**KEY**

<input type="checkbox"/> X	= Where pain starts	<input type="checkbox"/> [Diagonal Lines]	= Worst intense pain	<input type="checkbox"/> [Dotted]	= Less severe pain
<input type="checkbox"/> [Dashed]	= Shooting pain travels any distance from where it starts to where it stops	<input type="checkbox"/> [Checkmark]	= Numbness/tingling/pins & needles		

## Review of Systems - Check if you Have

	Yes	No
<b>Musculoskeletal</b>		
Neck Pain		
Stiffness		
Back Pain		
Stiffness		
Joint Pain		
Stiffness		
Redness		
Swelling		
<b>Cardiovascular</b>		
Chest Pain at rest		
Chest Pain with exercise or exertion		
Irregular Heart Rate		
Chest Pain with Shortness of Breath		
Do you take Nitroglycerine		
Leg Ulcers		
Dizziness/Lightheadedness		
Bleeding or Bruises		
<b>Pulmonary</b>		
Shortness of Breath		
Persistent or Worsening Cough		
Cough up Blood		
<b>Gastrointestinal</b>		
Unexplained Weight Loss Anorexia, Bulimia		
50 pounds overweight		
Drink Milk/Take Calcium		
Constipation		
Diarrhea		
Blood in Stool		
<b>Genito/Urinary</b>		
Are you / Could you be Pregnant		
Breast Feeding		
Blood in Urine		
Frequency of Urination		
Difficulty in Urinating		
Erectile Dysfunction		
<b>Neurologic</b>		
Memory Loss		
Loss of Balance		
Headaches		
Head Injuries		
Seizures		

## Social History - Check if you...

	Yes	No
Married		
Single with significant other		
Live with parents		
Live alone		
Live on education campus		
Nursing home		
Do you smoke/Chew tobacco		
I smoke less than 1 pack per day		
I smoke more than 1 pack per day		
Attempted to quit smoking – unsuccessful		
Do you drink alcohol		
I drink more than 4 ounces of alcohol a day		
Do you have stairs into your home		
Upstairs/Downstairs bathroom		
... shower		
Do you use crutches, cane, walker, wheelchair, or braces		
Are you the primary caregiver for any other person?		
Are there other personal issues you would like to discuss with your physician?		
We encourage you to talk to your orthopaedic surgeon about family violence.		
Participate in sports regularly		
Enjoy activities on a regular basis		
Occasionally have weakness		
I sleep eight hours each night		
I take afternoon naps		
I have energy throughout the day		
I exercise at least 3 times a week		
I feel calm throughout the day		
Do you feel full of pep		
Are you a nervous person		
Have felt down hearted or blue		
Have felt calm and peaceful		
Do you feel worn out		
Are you a happy person		
My health is excellent		
Generally feel happy throughout day		

Place Patient Label Here

*I certify that all information provided on this form is true and complete and I understand that the physicians at Winchester Orthopaedic Associates, Ltd. will be relying on this information in connection with my health care.*

Signature: \_\_\_\_\_