FAIRFAX ORTHOPAEDICS PATIENT HISTORY FORM

Name: ________________________________Date of Birth_____________ Age________ Ht________ Wt________

Primary Care Doctor:________________________________ Who referred you? ______________________________

Description of problem:____

Accident or Injury?____

How long have you had the problem?____

How severe is the pain?____

Is the pain sharp or dull?____

Are there associated signs of swelling, numbness, tingling or weakness?____________________________________

Have you had a similar problem in the past?____

Have you had previous treatment for this problem?____

Are you taking any medications for this problem?____

Have you had any previous evaluations with X-ray, MRI, CT or labs for this problem?__________________________

PAST MEDICAL HISTORY Please circle: Diabetes, High blood pressure, Lung disease, cancer, stroke, kidney disease, heart disease, thyroid disease, gout, infections, blood clots, phlebitis

PAST SURGICAL HISTORY: List prior operations____

PRESCRIPTION MEDICATIONS: ____

NON-PRESCRIPTION MEDICATIONS: ____

FAMILY HISTORY Please circle: Diabetes, High blood pressure, Lung disease, cancer, stroke, kidney disease, heart disease, thyroid disease, gout, infections, blood clots, phlebitis

SOCIAL HISTORY:

Marital status: single married separated/divorced widowed

Alcohol use never 1-2 per day 1-2 per week 1-2 per month

Tobacco use: never quit less than 1 pack per day more than 1 pack a day

Sports / Activities____

Hobbies____

Allergies:____

Do you have any metal allergies? ____

REVIEW OF SYSTEMS: Have you experienced any of the following in the past six months? Circle if yes

Constitutional
- Recent weight loss
- Fever
- Fatigue
- Recent weight gain

Gastrointestinal
- Loss of appetite
- Change in bowel movement
- Nausea / vomiting
- Diarrhea
- Blood in stool
- Stomach pain

Genitourinary
- Frequent urination
- Painful urination
- Blood in urine
- Incontinence

ENT
- Hearing loss
- Ringing in ears
- Earaches
- Nose bleed

Neurological
- Headaches
- Dizziness
- Seizures
- Tremors

Psychiatric
- Memory loss / confusion
- Nervousness
- Depression
- Sleep problems

Respiratory
- Cough
- Shortness of breath
- Wheezing

Eyes
- Blurred vision

Endocrine
- Excessive thirst
- Dry skin
- Heat / cold intolerance

Hematologic
- Slow healing after cuts
- Easy bruising

Skin
- Rash or itch
- Change in skin color
- Varicose veins

Cardiovascular
- Chest pain
- Swelling of feet and ankles

____ __________________

Patient Signature **Date**