

# FAIRFAX ORTHOPAEDICS, PLLC

3301 WOODBURN ROAD #208  
ANNANDALE, VA 22003  
PHONE: 703-560-9495 FAX: 703-698-7237

*We are grateful for your patience in filling out these forms. These forms allow us to render a higher quality of care!*

## PATIENT HISTORY

PATIENT NAME:			DATE:	HOME (    )
				WORK (    )
DATE OF BIRTH: /    /	AGE:	HEIGHT:	WEIGHT:	CELL (    )
OCCUPATION:				OTHER (    )

COMPLAINT	DATE OF ONSET
REASON FOR TODAY'S VISIT:	Please list date associated with the MOST RECENT period of pain (which brought you to our office)
DESCRIPTION OF PROBLEM: _____ _____ _____ _____ _____	/            /
	IS THERE HISTORY OF ANY PRIOR RELATED PROBLEM?    Y    N    (If Yes, Please Explain)
	_____ _____ _____

IS THIS INJURY DUE TO A WORKMAN'S COMP CLAIM OR AUTO ACCIDENT?    Y    N	IF SO, WHERE DID THIS INJURY OCCUR?	DATE OF INJURY:
DESCRIPTION OF HOW INJURY OCCURRED: _____		

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING:

FEVER, CHILLS, SWEATS   
  RASHES   
  WEIGHT GAIN / LOSS   
  CHANGES IN BOWEL OR BLADDER HABITS

## MEDICAL HISTORY

PRIMARY CARE DOCTOR/INTERNIST:	PATIENT HISTORY		
OTHER MEDICAL DOCTORS:	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> HIGH BLOOD PRESSURE
PLEASE EXPLAIN ANY PAST/CURRENT MEDICAL CONDITIONS THAT ARE CHECKED OFF IN THE BOX TO THE RIGHT (YOUR OWN HISTORY): _____ _____ _____	<input type="checkbox"/> DIABETES	<input type="checkbox"/> BONE/JOINT PROBLEMS	<input type="checkbox"/> THYROID DISEASE
	<input type="checkbox"/> CANCER	<input type="checkbox"/> LUNG DISEASE	<input type="checkbox"/> INFECTIONS
	<input type="checkbox"/> OTHER		

PATIENT FAMILY HISTORY	<input type="checkbox"/> HEART DISEASE <input type="checkbox"/> KIDNEY DISEASE <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> DIABETES <input type="checkbox"/> BONE/JOINT PROBLEMS <input type="checkbox"/> THYROID DISEASE <input type="checkbox"/> CANCER <input type="checkbox"/> LUNG DISEASE <input type="checkbox"/> INFECTIONS <input type="checkbox"/> OTHER	<input type="checkbox"/> PLEASE EXPLAIN ANY PAST/CURRENT MEDICAL CONDITIONS THAT ARE CHECKED OFF IN THE BOX TO THE LEFT (YOUR FAMILY HISTORY): _____ _____ _____
------------------------	---	---

# FAIRFAX ORTHOPAEDICS, PLLC

3301 WOODBURN ROAD #208  
ANNANDALE, VA 22003  
PHONE: 703-560-9495 FAX: 703-698-7237

## PATIENT HISTORY CONTINUED

ALLERGIES		CURRENT MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION)		
<b>ARE YOU ALLERGIC TO LATEX PRODUCTS?</b> Y    N	<b>ARE YOU ALLERGIC TO ANY MEDICATIONS?</b> Y    N	If you have a copy of your medication that you would like for us to copy, we would be more than happy to make a copy of them for you and place it in your chart.		
<b>MEDICATIONS YOU ARE ALLERGIC TO:</b> _____		MEDICATION	1. _____	DOSE: _____
<b>REACTIONS TO THESE MEDICATIONS:</b> _____			2. _____	DOSE: _____
<b>OTHER ALLERGIES / INFORMATION:</b> _____			3. _____	DOSE: _____
			4. _____	DOSE: _____
		<b>ANY ADDITIONAL MEDICATION RELATED INFORMATION:</b>		
PRIOR SURGERY		ADDITIONAL INFORMATION		
<b>PLEASE LIST ANY SURGERIES THAT ARE RELATED TO YOUR CURRENT COMPLAINT:</b>		<b>PLEASE USE THIS SPACE TO MENTION ANY ADDITIONAL INFORMATION THAT SHOULD BE BROUGHT TO OUR ATTENTION. THANK YOU.</b>  _____ _____ _____ _____ _____ _____		
<b>PLEASE LIST ANY SURGERIES THAT ARE NOT RELATED TO YOUR CURRENT COMPLAINT:</b>				
OTHER				
<b>SPORTS ACTIVITIES:</b>				
<b>HOBBIES:</b>				
<b>PRESENT EXERCISE REGIMEN:</b>				
<b>DO YOU SMOKE TOBACCO?</b>	Y    N	<input type="checkbox"/> HABITUAL <input type="checkbox"/> SOCIAL <input type="checkbox"/> OCCASIONAL	_____ x /day /wk /mth	<b>QUITTING?</b> YES    NO
<b>DO YOU DRINK ALCOHOL?</b>	Y    N	<input type="checkbox"/> HABITUAL <input type="checkbox"/> SOCIAL <input type="checkbox"/> OCCASIONAL	_____ x /day /wk /mth	<b>MOSTLY</b> BEER    WINE    SPIRITS
<b>DO YOU USE MOOD ALTERING DRUGS?</b>	Y    N	<input type="checkbox"/> HABITUAL <input type="checkbox"/> SOCIAL <input type="checkbox"/> OCCASIONAL	_____ x /day /wk /mth	<b>WHAT KIND?</b> _____

*Thank you for taking the time to fill out the paperwork fully. We know that at times it may seem tedious, but the information you have just given us is truly important in helping us to provide you with the very best care here at Fairfax Orthopaedics. We appreciate your time and detail.*

*Sincerely,*

**SAMUEL HAWKEN, MD**  
**MICHAEL CASSIDY, MD**  
**ROBERT STINGER, MD**  
**COLLEEN KENNEDY, MD**

*and staff.*