Fairfax orthopaedics FXO

***NEW* PATIENT HISTORY FORM** MR#_____ Today's Date:_____

Patient's Name:_____ DOB:_____ Age:_____ Ht.:_____ Wt.:_____
Primary Care Doctor:_____ Who Referred You?_____
Reason For Today's Visit:_____
_____
Description of Problem:_____
_____
How Long Have You Had the Problem?_____ Severity: 1/2/3/4/5/6/7/8/9/10 Accident/Injury?_____
Quality of Pain: Sharp/Dull:_____ Timing: (Constant/Occasional/Day/Night?)_____
What Makes it Better or Worse?_____
Any Associated Signs/Symptoms (Swelling/Numbness/Tingling?)_____
Has it Occurred Prior to this Episode?_____
Previous Treatment? (Physical Therapy/Injection/Medication)_____
_____
Previous Evaluation?(Lab Work/X-Ray/MRI)_____
Are you taking any medication for this problem?_____

Your Past Medical History(Circle):

Diabetes/Hypertension/Heart Disease/Lung Disease/Cancer/Stroke/Kidney Disease/Thyroid/Infection/Seizures
Other Problems or Additional Information:_____
History of Blood Clots or Phlebitis? Yes/No _____

Your Family History(Circle):

Diabetes/Hypertension/Heart Disease/Lung Disease/Cancer/Stroke/Kidney Disease/Thyroid/Infection/Seizures
Other Problems or Additional Information:_____

Current Medications (Please list with dose if known):
_____
_____
Non-Prescription Medication/Vitamins/Supplements/Herbs:_____
_____
Past Surgical History (Please List): _____
_____
_____

Social History:
Marital Status: Single/Married/Separated/Divorced/Widowed *Alcohol:* Never/Rarely/Moderate/Daily
Tobacco: Never/Occasionally/Daily/Previously but Quit
*Sports/Activities:*_____
*Hobbies:*_____

Allergies: Penicillin/Sulfa/Aspirin/Other:_____

PATIENT SIGNATURE_____**PROVIDER SIGNATURE**_____

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Have you experienced any of the following in the past six months? Circle if yes.

Constitutional

Recent weight change
Fever
Fatigue
Headaches

Eyes

Blurred vision

ENT

Hearing loss
Ringing in ears
Earaches
Nosebleed
Sore throat

Cardiovascular

Chest pain
Swelling of feet and ankles

Respiratory

Cough
Shortness of breath
Wheezing

Gastrointestinal

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

Skin

Rash or itch
Change in skin color
Varicose veins

Genitourinary

Frequent urination
Painful urination
Blood in urine
Incontinence

Neurological

Headache
Dizziness
Seizures
Tremors
Paralysis
Numness/tingling

Psychiatric

Memory loss/confusion
Nervousness
Depression
Sleep problems

Endocrine

Excessive thirst
Dry skin
Heat/cold intolerance

Hematologic

Slow healing after cuts
Easy bruising

PATIENT SIGNATURE_____

PROVIDER SIGNATURE_____