Virginia Spine & Sport Orthopaedics **Patient History- Page 1**

Please answer ALL questions

Name: _____

Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Male ☐ Female ☐

Hand Dominance: Right ☐ Left ☐

Occupation: _____
Marital Status: _____

Medication Allergies ☐NKDA

_____
_____
_____
_____

Specific reason for seeing Orthopaedic Surgeon:

_____
_____

Symptoms began/ Date of injury:

_____
_____

Past Medical History ☐**None**

*** (List ALL medical problems)***

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Previous Surgical History ☐**None**

Procedure Date Complications?

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Date: _____

How did you hear of our practice?

_____

Family Doctor (PCP): _____

Present Medications **LIST ALL**

Name Dose Frequency

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

Social History: ☐**None**

Current Smoker ☐ Yes ☐ No

If yes, how much: _____

If past smoker, when did you quit: _____

Alcohol Consumption: ☐ Social ☐ Moderate

☐ Heavy ☐ None

Do you use drugs : ☐ Yes ☐ No

If yes, name substance: _____

Family History:	**Yes**	**No**
Heart Disease	☐	☐
Diabetes	☐	☐
Anesthetic Reaction	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Scoliosis	☐	☐

Other: _____

Review of Systems for the last 12 months
Page 2

Name: _____
Date: _____

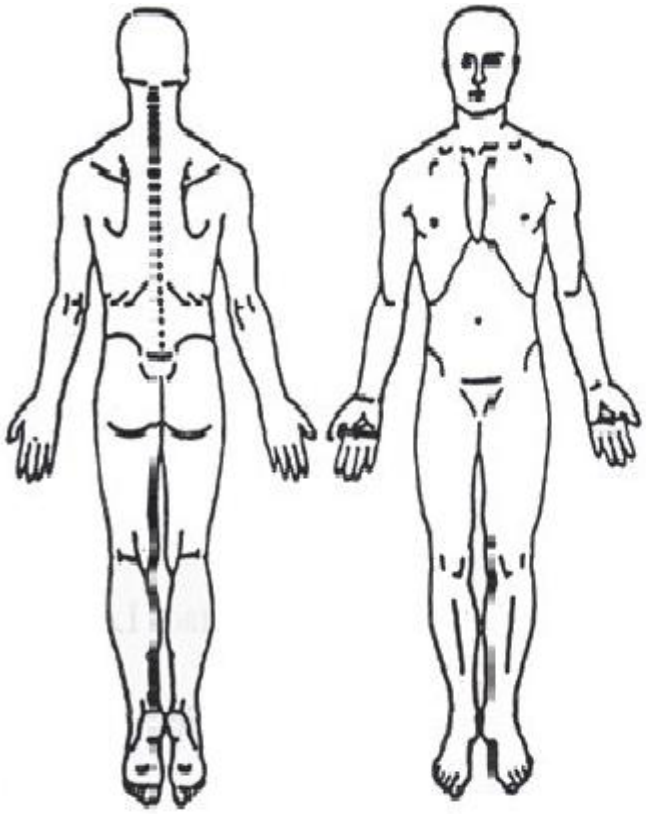
General	**Yes**	**No**
Loss of energy	☐	☐
Unusual chills	☐	☐
Night sweats	☐	☐
Unusual fever	☐	☐
Weight gain (unintentional)	☐	☐
Weight loss (unintentional)	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Memory loss/Dementia	☐	☐
Sleep Disturbance	☐	☐
Personality Change	☐	☐
Poor attention/attention deficit	☐	☐
Ophthalmic- Eyes		
Blurred vision	☐	☐
Wear glasses/contacts	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Macular degeneration	☐	☐
Ear, Nose, Throat		
Hearing problems	☐	☐
Hoarseness	☐	☐
Swallowing difficulty	☐	☐
Ear pain	☐	☐
Tooth pain	☐	☐
Allergy/Immunology		
Seasonal allergy/hay fever	☐	☐
Shellfish allergy	☐	☐
Hematology/Lymphatic		
Anemia	☐	☐
Bruise easily	☐	☐
Excessive bleeding	☐	☐
History of blood transfusion	☐	☐
Dermatological		
Bruise easily	☐	☐
Masses/cysts	☐	☐
Melanoma	☐	☐
Skin lesions	☐	☐
acne	☐	☐

Endocrine		**Yes**	**No**
Diabetes controlled by:	Insulin	☐	☐
	Oral Meds	☐	☐
	Diet	☐	☐
Thyroid Disease		☐	☐
Cardiovascular			
Chest Pain		☐	☐
Palpitation/irregular heartbeat		☐	☐
Hypertension		☐	☐
Heart attack or heart failure		☐	☐
High Cholesterol		☐	☐
Respiratory			
Shortness of breath		☐	☐
Asthma		☐	☐
Unusual cough		☐	☐
Emphysema/COPD		☐	☐
Gastrointestinal			
Abdominal pains		☐	☐
Ulcers		☐	☐
Acid reflux		☐	☐
Change in bowel habits		☐	☐
Hepatitis		☐	☐
Genitourinary			
Pain with urination		☐	☐
Blood in urine		☐	☐
Kidney stones/disease		☐	☐
Weak urinary stream		☐	☐
Incontinence		☐	☐
Urinary retention		☐	☐
Musculoskeletal			
Unusual joint/muscle pain		☐	☐
Degenerative Arthritis		☐	☐
Rheumatoid Arthritis		☐	☐
Osteoporosis/osteopenia		☐	☐
Prior neck/back pain		☐	☐
Neurological			
Dizziness		☐	☐
Headaches		☐	☐
Epilepsy/seizures		☐	☐
Numbness/tingling in extremities		☐	☐

Sign: _____ Date: _____

VIRGINIA
SPINE & SPORTS ORTHOPAEDICS

Patient name: _____ Date: _____



Location and type of pain:
Please mark diagram below

Numbness:
- - - - - - - - - -
- - - - - - - - - -

Pins/needles:
x x x x x x x x
x x x x x x x x

Burning:
/ / / / / / / /
/ / / / / / / /

Pain:
o o o o o
o o o o o

Stabbing:
+ + + + + +
+ + + + + +

How often is your pain? ☐ **Constantly** ☐ **Intermittently : Onset?** ☐ **Sudden** ☐ **Gradual**

Please rate your pain score (using a scale of 0 to 10, 0 = no pain and 10 =unbearable pain)
_____ **Pain scale** _____ **Without Activity** _____**With Activity**

What makes the pain better? (e.g. heat, cold, sitting, laying down, meds)
_____

What makes the pain worse? (e.g. bending, lifting, standing)
_____

Have you taken part in any conservative treatment for current problem?
☐ **Physical Therapy** ☐ **Chiropractor** ☐ **Meds** ☐ **Injections** ☐ **Massage**

Did conservative measures help ☐ **Yes** ☐ **No**

Please list any health care professionals who have treated you for this specific problem in the past: _____