West Virginia University
University Orthopaedics & Sports Medicine
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Date: _____
D.O.B:_____
Age: _____
Gender:___M ___F

Patient History Form

NAME (print):_____

Referred here by: (check one) □ self □ family □ friend □ doctor □ attorney

Name of Person/Physician making referral:_____
Primary Care Physician/Family Doctor:_____
Please describe the reason for your visit: Body Part right left both

Acute Injury-new (circle one) yes no Chronic Symptoms-old (circle one) yes no
How did your symptoms begin? If sudden, describe onset:_____
_____
On a scale of 1-10 (10 being most severe) circle # that best describes your pain 1 2 3 4 5 6 7 8 9 10
Approximate date symptoms began or date of injury:_____
Resulting from: (check which applies) □ Sports □ Accident □ Work Related □ Involving litigation
Are symptoms: (check which applies) □ constant □ intermittent □ worsening □ improving
Check all that apply: □ pain □ stiffness □ swelling □ instability □ weakness □ numbness/tingling
What makes symptoms worse?_____
_____
What makes symptoms better?_____
_____
What previous or formal treatment have you had? (medications, therapy, surgery,injections)_____
_____
Were previous treatments helpful to any degree? If so what?_____
_____

PAST SURGICAL HISTORY AND/OR HOSPITALIZATION

Previous: Type of Operations or reason for Hospitalization Year
1)_____ _____
2)_____ _____
3)_____ _____
4)_____ _____
5)_____ _____

Any previous fractures? □YES □NO If yes, what body part?_____ _____
Any other serious injuries? □YES □NO If yes, what happened and when?_____
_____

MEDICATION INFORMATION

Drug Allergies: Do you have any drug allergies? □ YES □ NO Allergic to Latex? □ YES □ NO
If yes, name the drug and the type of reaction. (example: rash, nausea, etc.) PLEASE BE SPECIFIC._____
_____

CURRENT MEDS: (List any medications you are taking at this time. Includes such items as aspirin, vitamins, laxatives, calcium, etc.)

NAME OF DRUG	**DOSE**(include strength & Number of pills per day)	How long have you Taken this medication?	Please Check: Helped? A lot	Some	Not At All
1)			□	□	□
2)			□	□	□
3)			□	□	□
4)			□	□	□
5)			□	□	□
6)			□	□	□
7)			□	□	□
8)			□	□	□

MEDICAL HISTORY/REVIEW OF SYSTEMS

Please check if you have had any of the following:	YES	NO		YES	NO
GENERAL----------	---------	--------	**CARDIOVASCULAR**----------	--------	-------
Are you currently pregnant?			Chest pain		
Diabetes			Heart attack		
Stroke			Palpitations		
Kidney disease			High blood pressure		
Ulcers			Shortness of breath		
Asthma or lung disease			Ankle swelling		
Cancer TYPE:			**HEMATOLOGIC**----------	---------	--------
Fatigue			Anemia		
Weakness			Blood clots		
Fevers			Bleeding tendency		
Skin problems/disorders TYPE:			Easily bruised		
Rheumatic fever			Circulatory problems		
Tuberculosis			Blood thinners (currently on)		
Recent weight loss/gain. How much?			(if yes, type?)	-------	--------
BLOODBORNE PATHOGENS----------	---------	--------	Phlebitis		
HIV/AIDS			**MUSCULOSKELETAL**----------	--------	--------
Hepatitis			Joint pain		
Other			Joint swelling		
SITES OF INFECTION----------	--------	--------	Muscle weakness		
Urinary			Muscle tenderness		
Dental			Morning stiffness		
Other			Arthritis/osteoarthritis		
NEUROLOGICAL----------	---------	---------	Rheumatoid arthritis		
Headaches			Bunions		
Dizziness			Osteoporosis		
Fainting			Previous bone density test? When?		
Memory loss			Bone/joint infections		
Loss of consciousness			Gout		
Muscle spasms			**PSYCHOLOGICAL**----------	--------	--------
Numbness or tingling of hands/feet			Depression		
Blindness or trouble seeing			Anxiety disorder		
Deafness or trouble hearing			Other		
Seizures					

Other illnesses or diseases which are not listed? Please describe._____

FAMILY HISTORY

Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:

	YES	NO		YES	NO
Diabetes (sugar)			Abnormal bleeding tendencies		
Heart disease			Rheumatoid arthritis		
Anesthetic complications			Osteoarthritis		
Cancer TYPE:			Gout		

_____

SOCIAL HISTORY

Occupation:_____# of years_____Duties_____
Do you smoke? (check one) □ YES □ NO □ PAST If yes or past, # of packs per day_____ years_____
Are you (check one) □ Right handed □ Left handed □ Both
Do you consume alcohol? (check one) □ YES □ NO If so, how many drinks per week?____Is there a history of abuse? □YES □NO
Have you ever had a problem with drugs? (check one) □ YES □ NO
Do you participate in recreational drugs?(check one) □ YES □ NO □ PAST If yes or past, list type and amount._____
_____
Do you regularly wear your seat belt? (check one) □ YES □ NO
Please list all sports and hobbies you are involved in:_____
What is your principle support system? Example, spouse, family, church_____
I as the patient, state the information is correct and accurate to the best of my knowledge.
(patient signature)_____ Date_____

I have reviewed this information with this patient.
(M.D. signature)_____ Date_____