Premier Orthopedics of Virginia
HCAVa Physicians
AN HCA AFFILIATE

NAME_____ **TODAY'S DATE**_____

REASON FOR VISIT: (What is the problem? Example: right knee pain, left shoulder pain, arthritis, etc):

_____

History: (How and when did your problem begin?)

_____

_____

Please indicate any treatments you have had so far: (Check all that apply)

____None ____Injections ____Physical Therapy (how long and where) _____

____Surgery (when and where) _____

____Medications (for this problem) _____

Please categorize your pain: (Please circle one) none mild mild to moderate
moderate moderate to severe severe unbearable

My pain is: (Please circle all that apply) constant intermittent achy burning
deep superficial improving worsening

Modifying factors (What makes your pain better or worse? Please check all that apply)

____Better with activity ____Worse with activity ____Better with rest ____Worse with rest

____Better with sleep ____Worse with sleep ____better with medicines ____Nothing

____Changing positions help (describe):_____

Other Factors_____

_____

Past Medical History (Please check all that apply): ____**NEGATIVE**

____arthritis	____fibromyalgia	____gout	____hearing loss	____stroke
____coronary disease	____heart attack	____arrhythmia	____asthma	____COPD
____high blood pressure	____GERD	____ulcers	____thyroid disease	____hepatitis
____cancer	____anemia	____diabetes	____colitis	____neuropathy

____excessive bleeding ____DVT (clots) ____osteoporosis ____pulmonary embolism

Past Surgical History (Please list any prior surgeries and approximate dates): **_____NEGATIVE**

_____

_____

If you have had surgery, have you had any problems with anesthesia? Please explain:_____

_____

Do you have any of the following problems? (Please check all that apply) _____**NONE**

____recent weight loss or gain	____fever/chills	____blurred vision
____skin rashes	____headache	____hearing loss
____sore or dry throat	____shortness of breath	____chronic cough
____chest pains or tightness	____heart palpitations	____abdominal pains
____nausea or vomiting	____heartburn (reflux)	____body aches
____pain in multiple joints	____difficulty with urination	____constipation/diarrhea
____burning with urination	____swelling in arms or legs	____depression
____mood swings	____dizziness/balance problems	____skin bruising

Family History (Does anyone in your family have a history of the following?) Please check all that apply:

____arthritis	____stroke	____osteoporosis	____hearing loss	____mult. fractures
____coronary disease	____heart attack	____arrhythmia	____asthma	____COPD
____high blood pressure	____GERD	____ulcers	____thyroid disease	____hepatitis
____cancer	____anemia	____diabetes	____colitis	____neuropathy
____substance abuse	____DVT (clots)	____pulmonary embolism	____anesthesia problems	

Social History: (Please check the appropriate space):

Smoking history ____none ____less than one pk/day ____one pk/day ____two pks/day
____more than two pks/day ____prior smoker who quit…..when? _____

Alcohol Use ____none ____socially ____daily. If daily, how much and what do you drink?_____

Recreational Drugs Please list any recreational drug use_____
History of substance abuse? ____No ____Yes. Explain_____

Drug Allergies (Please check or list others): **___NONE**

____penicillin ____keflex or cephalosporins ____sulfa ____IVP dye

____aspirin Others:_____

_____

Current Medications (List all medications or supply us with a separate list): ____**NONE**

_____

_____

_____