Premier Orthopedics of Virginia
HCAVa Physicians
AN HCA AFFILIATE

NEW PATIENT FORM

Elbow & Knee

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Please **completely** fill in the appropriate boxes.

NAME:_____ TODAY'S DATE:_____

AGE_____ DATE OF BIRTH _____ HEIGHT _____ WEIGHT_____

ARE YOU RIGHT OR LEFT HANDED:_____ OCCUPATION:_____

CHIEF COMPLAINT: SHOULDER ELBOW KNEE OTHER:_____
(please circle)
RIGHT LEFT BOTH

REASON FOR VISIT:_____

_____

WHEN DID YOUR SYMPTOMS START?_____

DID YOU HAVE A SPECIFIC INJURY? (please circle) Yes No

IF YES PLEASE DESCRIBE:_____

WAS THE INJURY WORK RELATED? (please circle) Yes No

HOW SEVERE IS YOUR PAIN (On a scale of 0-10 with 10 being the worst pain ever felt)? _____

TYPE OF PAIN: Dull Sharp Throbbing Achy Stabbing Shooting Other_____
(circle all that apply)

DOES YOUR PAIN AWAKEN YOU FROM SLEEP? (please circle) Yes No

DO YOU GET PAIN WITH (circle all that apply):

Overhead Activities Throwing Lifting Carrying Reaching

Squatting Weight Bearing Activities At Rest Climbing Stairs

WHICH OF THE FOLLOWING SYMPTOMS IS THE MOST BOTHERSOM (please circle one):

Pain Weakness Stiffness Instability

DO YOU GET ANY OF THE FOLLOWING(circle all that apply):

Weakness Instability Swelling Clicking Numbness Night Pain

Stiffness Loss of Range of Motion Catching Tingling Neck Pain

OTHER SYMPTOMS:_____

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM (circle all that apply):

X-rays MRI EMG Physical Therapy Ice Heat

Medications Injections Surgery Other_____

Reviewed:_____

PAST MEDICAL HISTORY: (Please circle Yes or No for the following medical conditions)

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Heart Attack	Yes	No	Seizure	Yes	No	Pace Maker	Yes	No
Lung Disease	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	HIV/AIDS	Yes	No	Stomach Problems	Yes	No
Hepatitis	Yes	No	Blood Clots	Yes	No	Other_____		

PAST SURGERIES AND APPROXIMATE DATES:

_____

_____

DRUG ALLERGIES: _____

LATEX ALLERGIES _____

CURRENT MEDICATIONS: See Section D on Outpatient Summary List

FAMILY HISTORY: (any medical problems in your blood relatives)

Mother:_____ Father:_____ Siblings:_____

SOCIAL HISTORY: Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Currently Smoke, How may per day?_____ ☐ Quit/When:_____

Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily (how much):_____

Drug Use: ☐ Never ☐ Type and Frequency_____

REVIEW OF SYSTEMS: Do you have trouble with any of the following? (circle all that apply)

Headache	Eyesight	Hearing	Swallowing
Chest Pain	Shortness of Breath	Diarrhea	Constipation
Poor Circulation	Blood in Stool	Ulcers	Painful Urination

Patient's Signature _____ Date _____

Reviewed:_____