**West Virginia University**
University Orthopaedics & Sports Medicine
912 Somerset Boulevard, Suite 101
Charles Town, WV 25414
Phone: 304-725-BONE (2663)
Fax: 304-724-0053

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________________________