Virginia Orthopaedic Center

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Patient Master History

Date: ______________

Patient Name: ______________________________ Date of Birth: ______________ Sex: ______

HEALTH HISTORY OF THE PATIENT

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding disorders		
Alcoholism		
Serious Injuries		
Lung Disease		
Tuberculosis		
Phlebitis		
Anemia		
Stomach Ulcers		
Liver Trouble		
Thyroid Trouble		
Other Illnesses		

Explain all Yes answers:

____
____
____

Surgical Procedures (*include approx. dates*):

____
____
____
____
____

Current Medications and Dosage:

____
____
____

Allergies or Medicine: (None ❑)

____
____
____

FAMILY HISTORY

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Other		

SOCIAL HISTORY

Previous Occupation(s):

____
____
____

Married ❑ Single ❑ Divorced ❑

Are you Pregnant? Yes ❑ No ❑

Number of Children Living: ____________

Number of Pregnancies: ____________

Presently Living Alone? Yes ❑ No ❑

Smoke ________ packs per day.

Alcohol: Never ❑ Occasional ❑ Moderate to Heavy ❑

Drug Overuse: None ❑ Presently ❑ Past Problem ❑

Current Activities or Sports:

____
____
____

REVIEW OF SYSTEMS

Have you recently had or do you now have:

	Yes	No
Dizziness		
Falls		
Reading Glasses		
Change of Vision		
Loss of Hearing		
Ear Pain		
Hoarseness		
Nosebleeds		
Difficulty Swallowing		
Morning Cough		
Shortness of Breath		
Chills and Fever		
Heart or Chest Pain		
Abnormal Heartbeat		
Badly Swollen Ankles		
Calf Cramps with Walking		
Poor Appetite		
Toothache		
Gum Trouble		
Nausea or Vomiting		
Stomach Pain		
Ulcers		
Frequent Belching		
Frequent Loose Bowel Movements		
Blood in Bowel Movements		
Frequent Constipation		
Burning Urination		
Difficulty Starting Urination		
Get Up Every Night to Urinate		
Frequent Headaches		
Blackouts		
Seizures		
Frequent Rash		
Hot or Cold Spells		
Recent Weight Change		
Nervous Exhaustion		
Insomnia		
Depression		
Nervous Tension		
Women Only:		
Irregular Periods		
Vaginal Discharge		
Frequent Spotting		

Physician Signature: ______________________________ Date: ______________