AUGUSTA ORTHOPEDIC SURGERY, PLC
PATIENT MEDICAL INFORMATION

PATIENT NAME: ____**AGE:**_______**DATE:**__________________
OCCUPATION: ____
REFERRING PHYSICIAN: ____ **PHONE #:**________________________
FAMILY PHYSICIAN: ____ **PHONE #:**________________________
PHARMACY NAME: ____**PHONE #:**________________________

PLEASE DESCRIBE THE PROBLEM AND SYMPTOMS THAT YOU ARE SEEING THE DOCTOR FOR TODAY: ☐RIGHT ☐LEFT

____

WHEN DID THE PROBLEM BEGIN (MM/DD/YYYY) ____________________

Is problem due to an injury? ☐**YES/Date of injury:** __________☐**NO/Approximate onset of problem:** ___________

Is the problem work related? ☐ **YES** ☐**NO** Is the problem due to a motor vehicle accident? ☐ **YES** ☐ **NO**

Have you had a workers comp (work related) injury in the past? ☐ **YES** ☐ **NO** **DATE**: ______________________
If your accident did not occur in Virginia, please list the state: ____

Have you been treated by another physician/hospital for this problem? ☐ **YES** ☐**NO**

Have any tests been done? ☐ X-RAYS, ☐MRI, ☐ EMG, ☐CT Scan, ☐ Other: _______________________________
Have you had treatment/s for this problem? ____

☐ **Physical therapy** ☐**Medication** ☐**cortisone injections**

ALLERGIES: **No known drug allergies:** ☐ **Allergic/sensitive to Latex products** ☐**Contrast dye** ☐**Metal**

Please list all known medication allergies and reactions:

Allergy to:	Reaction		Allergy to:	Reaction:

MEDICATION: **(please list all medications you take with or without a prescription) (use additional paper if needed)**

Medication name:	Dosage/# per day		Medication Name:	Dosage/#per day

PAST MEDICAL HISTORY: please **CIRCLE** any of the medical conditions below that you have or have had in the past:

☐**No past medical problems**

Anemia	Chemical dependency	Seizures/Stroke	Cataracts
Blood Clots/Phlebitis	Anxiety or depression	Night Sweats	MRSA
Blood transfusion, previous	Colitis	Thyroid disorder	Recurrent infection
Asthma/shortness of breath	Diverticulitis	Diabetes	Psoriasis/skin rash
Emphysema/chronic bronchitis	Ulcer/stomach bleed	Kidney/Renal Disease	Weight loss/gain
High Cholesterol	Angina/heart failure/attack	Kidney/bladder infections	Other:
Cancer: Where?	Irregular heart beat	Hearing loss	
Hepatitis/jaundice/HIV	High Blood Pressure	Visual loss or glaucoma	

Patient account number:_______________________

SURGICAL HISTORY:

☐ **I DO NOT have a history of any previous surgeries** (Please skip to Family History)

Did you have any trouble with your surgery/anesthesia: ☐ No ☐ yes - describe: ___________________________

____

List of previous surgeries/hospitalizations includes:

Type of Surgery/Hospitalization:	When:	Where was surgery:	Surgeon:

Family History: Has anyone in your immediate family been treated in the past or are they currently receiving treatment for any of the following conditions: (*Please identify family member*)

Cancer _______________________ **Heart disease** _____________________**High blood pressure** _____________________
Diabetes ______________________**Lung disease**________________________

SOCIAL HISTORY:

Smoking Status: ☐Never Smoker ☐ Former Smoker ☐Current Smoker ___ packs per day for ____ years

Do you consume alcoholic beverages? ☐No ☐Yes - if yes number of drinks per week: __________

REVIEW OF SYSTEMS

Please describe anything that you are currently experiencing (detail).

If all systems are **normal** please check this box ☐ (No problems noted for any of these body systems.)

	No	Yes	Detail:		No	Yes	Detail:
Recent Illness				Nausea/vomiting			
Fever, Chills				Diarrhea			
Fatigue				Urinary frequency			
Weight gain/loss				Chronic kidney failure			
Blindness/vision changes				Stiffness			
Hearing loss				Back pain			
Sinus congestion				Joint pain/swelling			
Snoring				Muscle weakness			
Chest pain/pressure				Neck/shoulder pain			
edema				Rash/sores			
Elevated blood pressure				dizziness			
Exercise intolerance				headaches			
Cough/wheezing				Numbness/tingling			
Chest congestion				Speech difficulties			
Abdominal pain				Anxiety/depression			
GERD				Alcohol/drug abuse			

Are you **( ) right handed** or (**) left handed**?

What is your approximate ***weight*:** ______________ *height***:** _______________

Are you or could you be pregnant? ( ) YES ( ) NO

Patient account number:_______________________