Winchester Orthopaedic Associates, Ltd.

Orthopaedic Offices
128 Medical Cir., Winchester, VA 22601 540.667.8975
1830 Amherst St., Winchester, VA 22601 540.536.4787

Physical Therapy Offices
130 Medical Cir., Winchester, VA 22601 540.667.7076
112 S. Reymann St., Ranson, WV 25438 304.725.3632
50-C Riverton Commons Dr., Front Royal, VA 22630 540.692.8977

NEW PATIENT INFORMATION

Patient's Name: _____Age: _____ Date of Birth: _____ Today's Date: _____

Birth Sex (biological): ☐Male ☐Female ☐Undifferentiated Current Gender (social): ☐Male ☐Female ☐Undifferentiated

Height: _____Weight: _____ Dominant Hand: ☐Right ☐Left ☐Both

Referring Doctor: _____ Family Doctor: _____

Occupation: _____ Employer/School: _____

Pharmacy: _____ How did you hear about our office? _____

Reason for your visit? Please describe which body part(s) and side (left, right or both): _____

_____

Date of Injury: _____ Was the injury related to an accident? ☐No ☐**Yes**; complete Accident Info on Registration Form

ALLERGIES Medication Allergies: ☐None ☐**Yes**; list:

Medication	Reaction

Other Allergies:

Latex Allergy/Sensitivity? ☐No ☐**Yes**

Metal Allergy? ☐No ☐**Yes**

Food or Other Allergy? ☐No ☐**Yes; list:**

Allergy	Reaction

MEDICATIONS you currently take (including over-the-counter, vitamins, herbs and prescribed drugs):

☐ See separate medication list

Medication	**Dose/Frequency**	**Prescribing Doctor**

****Ages 65 +, please answer the following:***

Have you had a fall in the past year? ☐No ☐**Yes** If yes, number of falls in past year _____

Did any fall result in fracture or other injury? ☐No ☐**Yes**

PATIENT MEDICAL HISTORY - Check if you have ever had any of the following…

☐Heart Trouble	☐Gout	☐Bleeding Problems	☐Anemia	☐AIDS/HIV
☐High Blood Pressure	☐Seizures	☐Serious Injuries	☐Stomach Ulcers	☐Hepatitis
☐Stroke	☐Sleep Apnea	☐Lung Disease	☐Liver Trouble	☐MRSA
☐Diabetes	☐Kidney Trouble	☐Asthma	☐Thyroid Trouble	☐Staph
☐Arthritis	☐Osteoporosis	☐DVT/Blood Clots	☐Cancer	☐VRE

Other:_____

Patient's Name: _____ Date of Birth: _____

Previous Surgeries: □*None*

Surgery	Date	Doctor	Hospital

After surgery, have you ever experienced:
Infection? □Yes □No Problems with anesthesia? □Yes □No Reaction to blood products? □Yes □No

Do you have Advance Directives? □Yes □No With which physician/facility?_____

FAMILY MEDICAL HISTORY - Mark if any of these conditions run in your immediate family and affected family member(s)

Condition	Father	Mother	Brother	Sister	Son	Daughter
Heart Trouble						
High Blood Pressure						
Stroke						
Diabetes						
Arthritis						
Gout						
Seizures						
Mental Illness						
Kidney Trouble						
Blood Disorder						
Cancer						
Alcoholism						

SOCIAL HISTORY

□Married □Single Do you live alone? □Yes □No If no, who do you live with? _____ # of children: _____
Do you exercise regularly? □Yes □No Type of activity/How often:_____
Tobacco Use? □Yes □No Type: _____ Amount per day: _____ # years used: _____
Alcohol Consumption? □Yes □No # Drinks per Week: _____ History of Alcoholism? □Yes □No
Recreational Drug Use? □Yes □No Type/Amt/How Often: _____ History of Substance Abuse? □Yes □No

REVIEW OF SYSTEMS - Check if you <u>currently</u> have, or have recently experienced, the following…

□Weight Change	□Ear Pain / Ringing	□Shortness of Breath	□Incontinence	□Numbness
□Fever / Chills	□Nosebleeds	□Cough	□Urinary Frequency	□Weakness
□Night Sweats	□Hoarseness	□Stomach Pain	□Urinary Burning	□Frequent Headaches
□Poor Appetite	□Difficulty Swallowing	□Nausea / Vomiting	□Pregnant	□Seizures
□Rash	□Tooth / Gum Trouble	□Frequent diarrhea	□Joint/Limb Swelling	□Blackouts
□Insomnia	□Visual Changes	□Frequent constipation	□Joint Pain	□Chronic Infection
□Depression	□Chest Pain	□Blood in Stool	□Lumps/Masses	□_____
□Anxiety	□Abnormal Heartbeat		□Backache	

Explain any conditions checked above (current treatment and treating physician): _____
_____

I certify that all information provided on this form is correct to the best of my knowledge. I will not hold my healthcare provider or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Legal Guardian: _____ Date: _____

Printed Name (patient/legal guardian): _____