SENTARA®

PATIENT HISTORY

Sentara RMH Orthopedics & Sports Medicine

Name: ____ Date of Birth: ______________ Gender: M F
First Middle Last

Email: ____________________ Phone: _________________Primary Care Provider:____________________________

Preferred Pharmacy: ______________________________ Do you have a living will? Yes No

Medications, Supplements, and Vitamins (please list anything you are currently taking)

____ ____
____ ____
____ ____
____ ____
____ ____

Allergies and Reactions

____
____

Current Symptoms (Do you have any of these symptoms today?)

Constitutional

N	Y	Symptom
N	Y	Chills
N	Y	Fatigue
N	Y	Malaise
N	Y	Night Sweats
N	Y	Weakness
N	Y	Weight Gain
N	Y	Weight loss

Cardiovascular

N	Y	Symptom
N	Y	Calf pain
N	Y	Chest pain
N	Y	Cyanosis
N	Y	Heart Murmur
N	Y	Irregular Heart Beat
N	Y	Palpitations
N	Y	Leg Swelling
N	Y	Syncope (fainting)

Endocrine

N	Y	Symptom
N	Y	Cold intolerance
N	Y	Hair loss
N	Y	Heat intolerant

Integumentary

N	Y	Symptom
N	Y	Contact allergy
N	Y	Itchy skin
N	Y	Rash
N	Y	Skin infection
N	Y	Skin lesion

HEENT

N	Y	Symptom
N	Y	Blurred Vision
N	Y	Double Vision
N	Y	Dysphasia (trouble swallowing)
N	Y	Ear Drainage
N	Y	Facial Pain
N	Y	Headache
N	Y	Hearing Loss
N	Y	Hoarseness
N	Y	Nasal congestion
N	Y	Ringing in ears
N	Y	Vertigo (dizziness)
N	Y	Vision loss

GI

N	Y	Symptom
N	Y	Abdominal Pain
N	Y	Constipation
N	Y	Black tarry stools
N	Y	Diarrhea
N	Y	Heartburn
N	Y	Jaundice
N	Y	Loss of appetite
N	Y	Nausea
N	Y	Vomiting

Neurologic

N	Y	Symptom
N	Y	Daytime sleepiness
N	Y	Difficulty walking
N	Y	Dizziness
N	Y	Poor coordination
N	Y	Memory loss
N	Y	Muscle weakness
N	Y	Paresthesia (numbness)
N	Y	Seizures
N	Y	Tremors

Hematologic

N	Y	Symptom
N	Y	Bleeding
N	Y	Bruising

Respiratory

N	Y	Symptom
N	Y	Chest Pain
N	Y	Cough
N	Y	Dyspnea (short of breath)
N	Y	Recent Infection
N	Y	TB Exposure
N	Y	Wheezing

Genitourinary

N	Y	Symptom
N	Y	Dysuria (painful urination)
N	Y	Frequent urination
N	Y	Blood in urine
N	Y	Urge incontinence
N	Y	Urinary incontinence

Musculoskeletal

This will be discussed during the office visit

Immunological

N	Y	Symptom
N	Y	Asthma
N	Y	Bee sting allergies
N	Y	Contact dermatitis (rash)
N	Y	Environmental allergies
N	Y	Food allergies
N	Y	Seasonal allergies

PAST MEDICAL HISTORY (please check if you have ever had or now have)

ENDOCRINE/METABOLIC
- ☐ Diabetes Mellitus
- ☐ Thyroid disease
- ☐ High Cholesterol

CARDIOVASCULAR
- ☐ Congestive heart failure
- ☐ High blood pressure
- ☐ Heart attack, Year: _______
- ☐ Valve problem
- ☐ Coronary artery disease
- ☐ Rheumatic fever
- ☐ Abnormal heart rhythm
- ☐ Irregular heart beat/ Atrial fibrillation.
- ☐ Pacemaker/Defibrillator
- ☐ Blood clot in leg(s)
- ☐ Heart bypass surgery
- ☐ Heart valve replacement
- ☐ Heart ablation treatment

ENT
- ☐ Sinus disease
- ☐ Ear disease

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

MUSCULOSKELETAL
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Back pain
- ☐ Polymyalgia Rheumatica

EYE
- ☐ Glaucoma
- ☐ Eye disease

GASTROINTESTINAL
- ☐ Liver disease
- ☐ Heartburn or reflux
- ☐ GI bleed
- ☐ Hepatitis; Type:______
- ☐ Ulcer
- ☐ Irritable bowel disease
- ☐ Crohn's Disease

PULMONARY
- ☐ Blood clot in lungs
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Asthma
- ☐ Asbestos related disease
- ☐ Pneumonia
- ☐ COPD
- ☐ Pulmonary Fibrosis

IMMUNOLOGIC
- ☐ Organ transplant
- ☐ Hay fever
- ☐ Hives
- ☐ Allergy - ______________

OTHER
- ☐ Lyme Disease
- ☐ Fibromyalgia
- ☐ Anemia
- ☐ Kidney disease
- ☐ Sleep Apnea If yes, treatment: ______________
- ☐ Dialysis

HEMATOLOGY/ONCOLOGY
- ☐ Cancer: ______________
- ☐ Blood transfusion
- ☐ Blood disorder: __________

INFECTIOUS DISEASE
- ☐ Serious infection Type:__________________
- ☐ Sexually transmitted disease: ______________
- ☐ HIV

NEUROLOGICAL
- ☐ Stroke
- ☐ Seizures/convulsions
- ☐ Degenerative neurological disease
- ☐ Head trauma/injury
- ☐ Migraine

GENERAL
- ☐ Disability for: __________ ______________________
- ☐ Other diseases:

Please list all surgeries along with date: ____

____

Have you or a family member ever had problems with anesthesia? ☐ No ☐ Yes ______________________________

FAMILY HISTORY

Is your family member **Living (L)** or **Deceased (D)**	Mother L ☐ D ☐	Father L ☐ D ☐	Brother L ☐ D ☐	Sister L ☐ D ☐	Children L ☐ D ☐
If deceased, what was the cause?					

Do any of the following diseases run in your family? If so, please check the diseases that do.

	Mother	**Father**	**Brother**	**Sister**	**Children**
High Blood Pressure					
Heart Disease/Heart Attack					
Diabetes					
Indicate Type 1, Type 2, or unknown					
Cancer (please write the type)					
Kidney Disease					
Stroke					
Blood disorders					
Arthritis					

SOCIAL HISTORY

Current Use of Tobacco: ☐ Never ☐ Used to – Quit Date: _____________ ☐ Current user – Packs per day: ___________

Do you drink alcohol? ☐ No ☐ Yes; Number of drinks per week: ______________

Have you ever or do you currently use illicit drugs? ☐ No ☐ Yes Hand Dominance: ☐ Right ☐ Left

Religion: _______________________________

Patient Name: ____ Date of Birth: _____________ Visit Date: ______________