COUNTRYSIDE ORTHOPAEDICS, PC PATIENT MEDICAL HISTORY **FAX (703) 858-1801**

Name: ______________________________ **Today's Date:** ____________________

Date Of Birth: _____/_____/____ **Age:** _______ **Height:** _________ **Weight:** ________ **BMI:** ________

Marital Status: **Single** **Married** **Divorced** **Separated** **Widowed**

Employed (occupation): ______________________________ **Homemaker** **Student** **Unemployed**

Primary Care Dr: ________________________ **Office Location:** _____________________ **Phone:** __________________

Reason for visit: Left Right____________________________ **Symptoms began/Date of injury**___________________

Current problem is the result: **Car accident** **Work accident** **Home accident** **Sports/recreational injury**

Other_____________________

What makes the pain worse? ________________________

Are you left or right handed? ________________________

ALLERGIES: ____

Current Medical Problems: __________________________

____

Current Medications (list all):

____

____

____

____

____

PREVIOUS SURGERIES (include year):

____

____

____

____

FAMILY HISTORY (Circle all that apply)

Heart Disease	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
Stroke	Yes	No
Arthritis	Yes	No
Alzheimers	Yes	No
Osteoporosis	Yes	No

What decreases your pain? _____________________

Do you smoke? Yes No
If yes, how much? ______________________
Do you drink alcohol? Yes No
If yes, how much? ______________________
Do you use drugs? Yes No
If yes, what substance? ___________________
Do you exercise? Yes No
If yes, how often? ______________________

REVIEW OF SYSTEMS (Have you ever had?)
Circle all that apply and what year

Heart Attack	Yes	No ___________
Irregular Heartbeat	Yes	No ___________
Heart Failure	Yes	No ___________
Stomach Ulcers	Yes	No ___________
Stroke/Mini Strokes	Yes	No ___________
High Blood Pressure	Yes	No ___________
Diabetes	Yes	No ___________
Kidney Disease	Yes	No ___________
Joint Pain	Yes	No ___________
Lung Disease	Yes	No ___________
Hepatitis	Yes	No ___________
Difficulty Urinating	Yes	No ___________
Epilepsy/Seizures	Yes	No ___________
Abnormal Bleeding	Yes	No ___________
Anemia	Yes	No ___________
Drug Reaction	Yes	No ___________
Anesthetic Reaction	Yes	No ___________
Cancer	Yes	No ___________
HIV/AIDS	Yes	No ___________

MEDICAL RECORDS RELEASE

I authorize and request the release of my medical records to:

Family Physician: ____________________________ Phone ______________________ Fax ____________________

Other Physician: _____________________________ Phone ______________________ Fax ____________________

List below those individuals you will allow Countryside Orthopaedics to disclose your personal health information to as necessary during the course of your health care services and treatment:

Name: ____ Relationship: ____________________________________

Name: ____ Relationship: ____________________________________

Patient/Guardian Signature: _________________________________ **Date:** ____________________________

Reviewed by (completed by MD/PA) Date and Initials