VIRGINIA ORTHOPAEDIC
101 Knotbreak Road| Salem, VA 24153
P: 540.444.4020 | F: 540.444.4021 | www.vaortho.com

James M. Farmer M.D.

New Patient Medical History for ELBOW Symptoms

Name: _____ Today's Date: _____
Age: _____ Phone number: _____
Referred by: _____ Date of Injury/Onset of symptoms: _____

Reason for visit. Describe injury or onset in detail: ❑ LEFT ❑ RIGHT _____

_____

_____

_____

Pain: ❑ Sharp ❑ Dull ❑ Stabbing ❑ Burning ❑ Other: _____
❑ Constant ❑ Intermittent **Intensity:** 0—1—2—3—4—5—6—7—8—9—10
Location (describe): _____
Does the pain go anywhere else (describe)? _____
What makes pain worse? ❑ Pushing ❑ Pulling ❑ Making tight grip ❑ Turning knobs ❑ Sleeping
❑ Driving ❑ Throwing ❑ Lifting Weights ❑ Other: _____
What makes pain better? ❑ Rest ❑ Activity Modification ❑ Ice/Heat ❑ Meds ❑ Brace
❑ Other: _____
What other symptoms are present? ❑ Catching ❑ Popping ❑ Grinding ❑ Locking ❑ Dislocation
❑ Subluxation ❑ Swelling (❑ constant ❑ fluctuates) ❑ Numbness/tingling
What treatments have you attempted and what effect? (PT, meds, injections) _____

_____

Can you work or participate in sports with current symptom? ❑ NO ❑ YES
Do you have light duty available at work? ❑ NO ❑ YES

Past Medical and Family History (check all that apply ❑ **You** ❑ **Family History**)

❑ ❑ High Blood Pressure	❑ ❑ Heart Disease	❑ ❑ Stroke	❑ ❑ Diabetes
❑ ❑ COPD	❑ ❑ Asthma	❑ ❑ Reflux	❑ ❑ Ulcers
❑ ❑ Kidney Disease	❑ ❑ Vascular Disease	❑ ❑ Hepatitis	❑ ❑ Blood Clots
❑ ❑ Bleeding Disorder	❑ ❑ Cancer	❑ ❑ Arthritis	❑ ❑ Seizures
❑ ❑ Headaches	❑ ❑ HIV		

❑ ❑ Other: _____

Past Surgical History ❑ (check all that apply)

❑ Appendectomy	❑ Gall Bladder	❑ Hernia	❑ Breast
❑ Heart Bypass	❑ Heart Valve	❑ Pacemaker	❑ Spine/Neck
❑ Arthroscopy	❑ Joint Replacement	❑ Rotator Cuff	❑ Hysterectomy

❑ Other: _____

Drug Allergies (list all known drug allergies)

_____

_____

Please complete both sides of form, sign and date.

Medications: (please list all prescription and over the counter medications and supplements)
❑ Separate List Attached

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Social History
❑ Single ❑ Married ❑ Divorced ❑ Widowed Children? ❑ NO ❑ YES # _____
Do you smoke? ❑ NO ❑ YES _____ packs per day
Do you drink alcohol? ❑ NO ❑ YES Do you use drugs? ❑ NO ❑ YES (list) _____
What is your occupation? _____
Do you exercise regularly? ❑ NO ❑ Yes _____ days per week
Do you participate in sports? ❑ NO ❑ YES (list) _____

Review of Systems
Do you currently or frequently have: ❑ (check all that apply)

Constitutional
❑ Weight loss
❑ Weight gain
❑ Fever
❑ Chills

Eyes
❑ Blurred vision
❑ Double vision

Ears, Nose, Throat
❑ Hearing loss
❑ Ringing in ears
❑ Congestion
❑ Sore throat

Respiratory
❑ Shortness of breath
❑ Wheezing
❑ Cough
❑ Coughing blood

Cardiovascular
❑ Chest pain
❑ Palpitations

Genitourinary
❑ Painful urination
❑ Blood in urine
❑ Urgency/frequency
❑ Incontinence

Gastrointestinal
❑ Nausea
❑ Vomiting
❑ Diarrhea
❑ Constipation
❑ Incontinence

Skin
❑ Rash
❑ Skin lesion
❑ Nail problems

Neurological
❑ Headaches
❑ Seizures
❑ Dizziness
❑ Balance problems
❑ Numbness/tingling
❑ Weakness

Endocrine
❑ Thirst
❑ Tired/sluggish
❑ Hot
❑ Cold

Hematologic
❑ Bleeding problems
❑ Bruising
❑ Limb swelling

Psychiatric
❑ Depression
❑ Anxiety
❑ Insomnia
❑ Addiction
❑ Drug use

Musculoskeletal (other than current complaint)
❑ Joint pain (list) _____
_____
_____
❑ Back pain
❑ Neck pain
❑ Joint stiffness
❑ Joint swelling
❑ Gout

Other Medical Concerns: (list)
_____
_____
_____
_____

Height: _____
Weight: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____