Winchester Orthopaedic Associates, Ltd.

Main Office	*Satellite Office (WMC Campus)*	*Physical Therapy*	*Winc. Orthopaedic Physical Therapy LLC*
128 Medical Cir., Winchester, VA 22601	1830 Amherst St., Winchester, VA 22601	130 Medical Cir., Winchester, VA 22601	112 S. Reymann St., Ranson, WV 25438
Tel: 540.667.8975 Fax: 540.667.6589	Tel: 540.536.4787 Fax: 540.667.6589	Tel: 540.667.7076 Fax: 540.667.5773	Tel: 304.725.3632 Fax: 304.725.8252

NEW PATIENT INFORMATION

Patient's Name: ________________________________Age: ______ Date of Birth: ___________ Today's Date: _________

Sex: ☐Male ☐Female 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 currently 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 doctor 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): ____