Virginia Commonwealth University

Medical Center

In the tradition of the Medical College of Virginia

Welcome to the VCU Medical Center. Please try to arrive 15-30 minutes early to allow time for parking and check in.

Please call us at 800-762-6161 if:

- You need to change or cancel this appointment. An appointment no-show may result in a fee being charged to you.
- Your insurance or contact information changes between now and the time of the appointment.

Please bring:

- A picture ID
- Your insurance card
- A list of all medicines that you are taking (including dosages) or bring medications in bottles
- Any papers the scheduling office asked you to provide
- Money for co-pay if needed
- A referral if needed; contact your Primary Care Provider
- X-rays (preferably on a CD) if performed; these can be obtained at the hospital where x-rays were performed

If a referral is needed and not obtained, we may have to reschedule your appointment. If our doctor sees you without one, you may have to pay for the entire cost of the visit, and any tests done at that time.

If you need help paying for your health care, call 828-0966 or 800-762-6161 to speak to our Financial Services staff.

Sometimes, due to unforeseen circumstances, the physician may have to reschedule appointments. Please provide us with sufficient contact information. We don't always have enough notice to mail you a letter if we are unable to reach you by phone.

Thank you for choosing VCU Medical Center for your health care needs. Please let us know if there is anything else you need.

Sincerely,

Orthopedics Department

New patient form

Department of Orthopaedic Surgery

Patient history

Patient Name:____Age:_________Height:____________Weight:_____

Primary Care Physician:____________________________ Please circle: I am RIGHT HANDED LEFT HANDED

Referring Physician:___________________________________Reason for your visit: ___________________________________

Describe how your injury or illness started: ____

Date of injury/illness onset:______________________Time:______________Location: ______________________________

Any previous treatment for this problem? Circle: No Yes If yes: _______

Circle any tests you have had for this problem: x-ray MRI CT scan EMG/NCS

Circle best answer: Are your symptoms getting: Better Worse Same

Pain is: constant (present all the time) comes and goes sharp dull throbbing aching burning

Does it wake you from sleep? Yes No What makes pain better? ____________________________________

On a scale of 0 – 10, (10 is worst imaginable pain) how severe is your pain? At rest:____________________________________

With activities: __________________________________

Past medical history: Are you currently receiving treatment or have you received treatment in the past for any of the following conditions? Circle below if YES:

Anemia	Cancer	High blood pressure	Scarlet fever
Arthritis	Currently pregnant	Kidney disease	STD
Asthma	Diabetes	Blood clots	Stroke
Birth defect	Heart disease	Recurrent infections	Thyroid disease
Bleeding disorder	Hepatitis	Rheumatic fever	Ulcers (GI)
Depression	Pneumonia	Intestinal disorder	

Others? ____

Please specify: List allergies and reactions: ____

____ If no known allergies, initial here _______

Past surgical history: Please list surgery, date surgery performed, name surgeon and hospital where performed.

Surgery:____________________________ Date performed:____________________________

Surgeon:____________________________ Hospital:___________________________________

Surgery:____________________________ Date performed:____________________________

Surgeon:____________________________ Hospital:___________________________________

List all current medications: Please include over the counter, herbal supplements and vitamins.

Medication name	Dose	How often	Last dose date/time

If no medications, initial here: ____________________

Family history: Has any family member been diagnosed or treated for any of the following conditions? Circle if YES:

Cancer	Diabetes	Heart disease	Neurological disorder
Tuberculosis	Kidney disease	Arthritis	Anesthesia issues

Please list health status or cause of death for the following family members:

Mother:________________Father:_______________________Siblings:_____________________Children: _________________

Social history: Marital Status __________ Occupation (full-time/Part Time or Student)_____________

Do you now or have you previously used tobacco products? Circle one: YES NO

If yes, type:_________________________Amount:__________per day

Do you consume alcoholic beverages? Circle one: YES NO

If yes, type:_________________________Amount:__________per day_______________per week

Review of symptoms: Please circle the symptoms you have experienced in the last 3 months:

Constitutional	**Eyes**	**Ear/Nose/Throat**	**Gastrointestinal**	**Cardiovascular**	**Head**
Fever	Blurring	Soreness	Nausea	Chest Pain	Headache
Night sweats	Photophobia	Sinus Drainage	Vomiting	Rapid Heart Beat	Seizures
Weight gain	Corrective Lens	Difficulty Swallowing	Constipation	Faintness	Neck pain
Weight loss	Discharge	Ringing Ears	Diarrhea	Swollen Limbs	Concussion
Fatigue	Vision Disturbance	Hearing Loss	Black Stools	Blood Thinners	

Integument	**Genitourinary**	**Musculoskeletal**	**Respiratory**	**Neurologic**	**Immunologic**
Eruptions/rash	Painful Urination	Weakness	Hard to breathe	Tingling	High Dose Steroids
Itching	Frequent Urination	Joint Pain	Bloody Sputum	Numbness	Chemotherapy
Skin Breakdown	Incontinence	Muscle Pain	Pneumonia	Balance Issues	Immunocomprised
Jaundice (yellow)	Infection	Joint Swelling	Productive Cough		

Psychiatric	**Endocrine**	**Hematological/Lymphatic**
Anxious	Heat Intolerance	Swollen Glands
Depressed	Cold Intolerance	Bruises

Patient signature:________________________**Physician signature:**____________________**Date:** __________