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Patient Account # _____

PATIENT MEDICAL HISTORY

Today's Date: _____

PERSONAL

NAME: _____ AGE: _____ SS#: _____ DOB: _____
 WEIGHT: ___ lbs. HEIGHT: ___ Ft. ___ In. SEX: M F BMI: _____ RIGHT LEFT HANDED
 OCCUPATION: _____ RETIRED: _____ EMPLOYER: _____
 REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____

HISTORY OF PRESENT ILLNESS

Please describe the problem and the symptoms that brought you here today.

Injury Date and Time: _____ No Injury

Motor Vehicle Accident Work Injury Sports Injury Arthritis Other: _____

Where is the pain? Neck With radiation to R Arm L Arm Other
 Back With radiation to R Leg L Leg
 Shoulder L R Elbow L R Wrist L R Hand L R
 Hip L R Knee L R Ankle L R Foot L R

How long have you had the pain? _____ Days _____ Months _____ Years
 LEAST MOST

How severe is the pain? 0 1 2 3 4 5 6 7 8 9 10

What is the pain like? Ache Sharp Dull Burn Radiating Other: _____

When does it hurt Constant On and Off Other: _____

Any associated symptoms? Numbness Swelling Stiffness Other: _____

Any Treatments? Medications _____ Surgery _____
 Physical Therapy _____ Other _____

Any Tests? X-RAYS CT MRI BONE SCAN NERVE TESTS BLOOD WORK

Done Where? _____

CURRENT MEDICATIONS

Name and Dose	Name and Dose	Name and Dose
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL CONDITIONS

(CHECK ALL THAT APPLY) NO ILLNESS

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> MENTAL/NERVE DISORDER |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DIABETES | <input type="checkbox"/> PANCREATITIS |
| <input type="checkbox"/> ANGINA | <input type="checkbox"/> ELEVATED CHOLESTEROL | <input type="checkbox"/> PHLEBITIS/BLOOD CLOTS |
| <input type="checkbox"/> ATRIAL FIBRILLATION | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> PNEUMONIA |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> GALL BLADDER DISEASE | <input type="checkbox"/> SKIN DISEASE |
| <input type="checkbox"/> BLADDER INFECTION | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> INTESTINAL PROBLEMS | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> OTHER: _____ |

ALLERGIES

PENICILLIN SULFA CODEINE SHELLFISH LATEX OTHER _____

PAST MEDICAL HISTORY

PREVIOUS SURGERY	_____	DATE _____
	_____	DATE _____
HOSPITALIZATIONS	_____	DATE _____
	_____	DATE _____
	_____	DATE _____

SOCIAL HISTORY

DO YOU SMOKE? NO YES _____ PACKS/DAY _____ YEARS
 DO YOU DRINK ALCOHOL? NO YES _____ AVERAGE WEEKLY CONSUMPTION

FEMALE PATIENTS Oral Contraception? NO YES Any chance you are pregnant? NO YES

FAMILY HISTORY

(CHECK ALL THAT APPLY) NO DISEASES

- | | | |
|--|---|--|
| <input type="checkbox"/> CANCER | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> EXCESSIVE BLEEDING |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> PROBLEM WITH ANESTHESIA |

OTHER: _____

REVIEW OF SYMPTOMS

(CHECK ALL THAT APPLY)

GENERAL

- None
- Fever
- Chills
- Weight Change

HEAD

- None
- Headaches
- Dizziness
- Hearing Loss
- Ringing in Ears
- Double/Blurred Vision
- Sore Throat/ Hoarseness
- Recent Cold

CHEST

- None
- Shortness of Breath
- Chest Pain
- Palpitations
- Wheezing
- Rheumatic Fever
- Heart Murmur

ABDOMEN

- None
- Nausea/Vomiting
- Difficulty Swallowing
- Gas/Bloating
- Indigestion

Abdominal Pain

- Diarrhea
- Bloody Stools
- Hemorrhoids

URINARY

- None
- Blood in Urine
- Burning Sensation
- Bladder/Kidney Infection
- Frequent Urinating
- Incontinence

ORTHOPEDIC

- None
- Fracture/Dislocation
- Sprain/Strain
- Tendonitis

- Joint Stiffness
- Joint Pain
- Rheumatoid Disease
- Gout
- Swelling of Feet

SKIN

- None
- Rash/Itching
- Psoriasis
- Reynaud's
- Varicose Veins

EMOTIONAL

- None
- Depression
- Bipolar Disorder
- Seizure Disorder

OTHER

PATIENT SIGNATURE _____ DATE _____