

TEAYS VALLEY ORTHOPEDICS
3703 Teays Valley Road
Hurricane, WV 25526
304-757-2273

PATIENT HISTORY

GENERAL INFORMATION		
Name	Home Phone	
Address	Cell Phone	
City	State	Zip
Date of Birth	Age	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Social Security Number		
Emergency Contact Information		
Name	Home Phone	
Relationship	Cell Phone	
May we leave a message?	P No	<input type="checkbox"/> Yes, with whom?
Which physician referred you to Teays Valley Orthopedics?		
Name	Specialty	Phone
Who is your primary care physician?		
Name	Specialty	Phone
Home Health Care/ Nursing Home		Phone
Pharmacy		Phone
Have you ever been a patient at Charleston Area Medical Center? P Yes P No		
SOCIAL HISTORY (please check one for each item)		
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Employer:		Job Duties:
Dominant Hand:	Y Right <input type="checkbox"/> Left	
Tobacco Use:	<input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit _____ years ago	Packs per day _____
Alcohol Use:	<input type="checkbox"/> Never Y Rarely Y Moderate Y Daily	
Drug Use:	<input type="checkbox"/> Never	Type/Frequency:
Caffeine Use:	Y Never	Type/Frequency:
MAIN COMPLAINT		
Location/ Body Part		
When did you first notice the problem?		
How did your problem start?		
Injury? P No Y Yes, When:		
How have you been treating your condition until now?		
Have you had any lab work in the past month? P No		<input type="checkbox"/> Yes, Who Ordered:
Have you had any x-rays, MRI, or CT scans done? P No		<input type="checkbox"/> Yes, Who Ordered:
Where was the tests performed?		
Have you had any other problems associated with your main complaint? (please check)		
Y Infection	Y Swelling	Y Other:
Signature	Date	Relationship