

Name: _____
DOB : _____
Date: _____

SOUTHERN CALIFORNIA ORTHOPEDIC INSTITUTE - PATIENT MEDICAL HISTORY

Sex: _____ Occupation: _____
Age: _____ Email: /Email _____

Referring Physician's Name: _____ Phone: _____

Physician's Address: _____ City: _____ State: _____

Are you right or left handed?

Ht: _____' , _____" Wt: _____ lbs Right Left

CC/Why are you here today? _____

Was there an injury? Yes No

If yes, how did you get injured? _____ Date of injury/Onset of Condition: _____

Is this a work related injury? Yes No

Was it reported? Yes No

Where is the pain/problem? _____

Does it travel to other areas? Yes No If yes, Where _____

How long has it been hurting? _____wk(s) _____mo(s) _____yr(s)

Rate your pain on a scale of 1-10, 10 being worst (please circle): 1 2 3 4 5 6 7 8 9 10

Quality of pain: Dull Throbbing Sharp If lump, is it Warm Tender Red

The pain is: Getting Better Staying the same Getting Worse

What makes the pain better? _____ Worse? _____

Activities you can no longer perform due to this injury? _____

Associated Symptoms: Popping Clicking Swelling Grinding Other _____

Have you seen any **other** physicians for treatment regarding this condition? Yes No

If yes, what is the physician's name: _____

Which of the following treatments have you had for **this** problem?

<input type="checkbox"/> None				
<input type="checkbox"/> Medications	Duration: _____	Did it help?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Physical Therapy	Duration: _____	Did it help?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Injections	Qty: _____	Did it help?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Brace		Did it help?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Crutches		Did it help?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Other: _____				
<input type="checkbox"/> Surgery	Date: _____	What type of Surgery? _____	Did it help?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Surgery	Date: _____	What type of Surgery? _____	Did it help?	<input type="checkbox"/> Yes <input type="checkbox"/> No

What type of test (s) have you had?

<input type="checkbox"/> None			
<input type="checkbox"/> MRI	Date: _____	Location: _____	
<input type="checkbox"/> X-Ray	Date: _____	Location: _____	
<input type="checkbox"/> Ultra Sound	Date: _____	Location: _____	
<input type="checkbox"/> EMG/NCV	Date: _____	Location: _____	

Name: _____
 DOB : _____
 Date: _____

GENERAL HISTORY (Cont.)

PAST HISTORY OF PRESENT ILLNESS:

Have you had any previous injury to this area? Yes No

Hobbies/Sports: _____

Have you ever had any of the following? Please check all pertinent boxes:

- | | | | |
|-----------------------------------------------|---------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Aids or HIV + | <input type="checkbox"/> Chronic Pain (CRPS) | <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Deep Venous Thrombosis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Auto-immune disorder | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Gastro Esophageal Reflux | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Valley Fever |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Gout | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Other (please list): |

Cancer: Type: _____
 Location/Treatment Received: _____
 Chemo Surgery Radiation

Medications: Include Non-prescription & Herbal Supplements (use reverse side of form if needed):

<input type="checkbox"/> Please See Attached List	<input type="checkbox"/> Please See Reverse Side						
Drug Name	Dosage	Frequency	Oral	Topical	Injection	IV	Other
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Drug Allergies: No known drug allergies

Medication	Reaction	Mild	Moderate	Severe	Unknown
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Tape Allergy: Yes No **Latex Allergy:** Yes No

Have you ever been diagnosed with osteoporosis or osteopenia? Yes No

Have you had a Bone Mineral Density Test (DEXA)? Yes No If yes, date of last test: _____

What were the results? _____

Past Surgical/ Hospitalization History (use reverse side if needed):

Date	Surgery/Illness	Doctor	Hospital, City, State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Social History:

Marital Status	Use of Tobacco	Use of Alcohol
<input type="checkbox"/> Single	<input type="checkbox"/> Never	<input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Daily
<input type="checkbox"/> Married	<input type="checkbox"/> Former Smoker	Number of times this past year you have had:
<input type="checkbox"/> Divorced	Start Date: _____ Quit Date: _____	5 or more drinks in one day? _____
<input type="checkbox"/> Widowed	<input type="checkbox"/> Current Daily Smoker	4 or more drinks in one day? _____
<input type="checkbox"/> Separated	Start Date: _____ Packs/Day: _____	
	<input type="checkbox"/> Current Occasional Smoker	
	Start Date: _____ Packs/Day: _____	
	Living Situation:	
	<input type="checkbox"/> With family <input type="checkbox"/> With Friends	
	<input type="checkbox"/> Alone <input type="checkbox"/> Other	

Name: _____
 DOB : _____
 Date: _____

GENERAL HISTORY (Cont.)

Family History:

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____

REVIEW OF SYSTEMS: Please check all pertinent boxes:

Musculoskeletal

- Joint Pain No Yes
- Joint Stiffness No Yes
- Weakness of muscles or joints No Yes
- Muscle pain or cramps No Yes
- Back Pain No Yes
- Cold Extremities No Yes
- Difficulty in walking No Yes

Constitutional symptoms

- Bad general health lately No Yes
- Recent weight change No Yes
- Fever No Yes
- Fatigue No Yes
- Headaches No Yes

Ears / Nose / Mouth / Throat

- Hearing loss or ringing No Yes
- Ear aches or drainage No Yes
- Chronic sinus problems No Yes
- Nose bleeds No Yes
- Bleeding Gums No Yes
- Sore throat or voice change No Yes
- Swollen glands in neck No Yes

Cardiovascular

- Heart trouble No Yes
- Chest pain or angina pectoris No Yes
- Palpitation No Yes
- Shortness of breathe while walking No Yes
- Swelling of feet or hands No Yes
- Increased Cholesterol No Yes

Allergic / Immunologic

List food / enviromental allergies:

Genitourinary

- Frequent urination No Yes
- Burning or painful urination No Yes
- Blood in urine No Yes
- Incontinence of dribbling No Yes
- Female - # of pregnancies _____
- Female - # of deliveries _____

Integumentary (skin, breast)

- Rash or itching No Yes
- Change in skin color No Yes
- Varicose veins No Yes
- Breast pain No Yes
- Breast lump No Yes

Neurological

- Light headed or dizzy No Yes
- Numbness or tingling No Yes
- Tremors No Yes
- Paralysis No Yes

Endocrine

- Excessive thirst or urination No Yes
- Heat or cold intolerance No Yes
- Skin becoming dryer No Yes

Hematologic / Lymphatic

- Slow to heal after cuts No Yes
- Bleeding or bruising tendencies No Yes
- Anemia No Yes
- Enlarged glands No Yes

Psychiatric

- Memory loss or confusion No Yes
- Nervousness No Yes
- Depression No Yes
- Insomnia No Yes

Gastrointestinal

- Loss of appetite No Yes
- Nausea or vomiting No Yes
- Frequent diarrhea No Yes
- Constipation No Yes
- Rectal bleeding, bloody stool No Yes
- Abdominal pain No Yes

Respiratory

- Chronic or frequent coughs No Yes
- Spitting up blood No Yes
- Shortness of breathe No Yes
- Wheezing No Yes

Eyes

- Eye disease or injury No Yes
- Wear glasses/contact lenses No Yes
- Blurred or double vision No Yes

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

 Signature of Patient or Parent of Minor

 Date

 Signature of Physician

 Date