SOUTHERN CALIFORNIA ORTHOPEDIC INSTITUTE - PATIENT MEDICAL HISTORY

Name: ______________________ **Date:** ______________________

Sex: __________ **Occupation:** ______________________

Age: __________ **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?

☐ None

☐ Medications Duration: __________ Did it help? ☐ Yes ☐ No

☐ Physical Therapy Duration: __________ Did it help? ☐ Yes ☐ No

☐ Injections Qty: __________ Did it help? ☐ Yes ☐ No

☐ Brace Did it help? ☐ Yes ☐ No

☐ Crutches Did it help? ☐ Yes ☐ No

☐ Other: ______________________

☐ Surgery Date __________ What type of Surgery? ______________________ Did it help? ☐ Yes ☐ No

Surgery Date __________ What type of Surgery? ______________________ Did it help? ☐ Yes ☐ No

What type of test (s) have you had?

☐ None

☐ MRI Date __________ Location ______________________

☐ X-Ray Date __________ Location ______________________

☐ Ultra Sound Date __________ Location ______________________

☐ EMG/NCV Date __________ Location ______________________

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:

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

☐ Cancer: Type: ____________________

Location/Treatment Received: ____________________

☐ Chemo ☐ Surgery ☐ Radiation

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

☐ Please See Attached List ☐ Please See Reverse Side

Drug Name	Dosage	Frequency	Oral	Topical	Injection	IV	Other
			☐	☐	☐	☐	☐ ______
			☐	☐	☐	☐	☐ ______
			☐	☐	☐	☐	☐ ______

Drug Allergies: ☐ No known drug allergies

Medication	Reaction	Mild	Moderate	Severe	Unknown
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

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

Have you had a flu vaccination? ☐ Yes ☐ No If yes, date of vaccination: ____________

Have you ever been diagnosed with osteporosis 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? ____________________

If you are age 66 or older, have you had a pneumonia vaccination? ☐ Yes ☐ No If yes, date: ____________

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

Date	Surgery/Illness	Doctor	Hospital, City, State

Patient Social History:

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Use of Tobacco
- ☐ Never
- ☐ Former Smoker
  Start Date:_________ Quit Date_______
- ☐ Current Daily Smoker
  Start Date:_________ Packs/Day_______
- ☐ Current Occasional Smoker
  Start Date:_________ Packs/Day_______

Use of Alcohol

☐ Never ☐ Moderate ☐ Daily

Number of times this past year you have had:

5 or more drinks in one day?_________

4 or more drinks in one day?_________

Living Situation:

☐ With family ☐ With Friends

☐ Alone ☐ Other

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:

Musculoskelatal

- 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 Cholesteral ☐ No ☐ Yes

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 thrist 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, blody 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

Allergic / Immunologic

List food / enviromental allergies:

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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**