SOUTHERN CALIFORNIA ORTHOPEDIC INSTITUTE

PATIENT MEDICAL HISTORY

Patient Name: _____ Birth date: _____ Sex: ❑ M ❑ F

Today's Date: _____ Date of Injury: _____ **Are you?** ❑ **Right-handed** ❑ **Left-handed**

Occupation: _____ Primary Care Physician: _____ Phone #: _____

Is this work related? ❑ **Yes** ❑ **No**

Were you sent to our office by a physician? ❑ **Yes** ❑ **No** If so, please provide: **Was it reported?** ❑ **Yes** ❑ **No**

Requesting Physician's Name: _____ **Phone #:** _____

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

HISTORY OF PRESENT ILLNESS:
(Physician: dictate 4 of the following) **Ht:** _____'_____" **Wt:** _____ **lbs.** **Age:** _____ **Problem with:** ❑ **Right Extrem.** ❑ **Left Extrem.**

CC / Why are you here today? _____

Location: _____ Quality: _____
Where is the pain/problem? Does it travel to other areas? Is the pain dull, throbbing, sharp? If lump, is it warm, tender, red?

Severity: _____ Duration: _____
How severe is the pain on a scale of 1 - 5 with 5 being the most severe? How long have you had this pain/problem? When did it start?

Timing: _____ Context: _____
Does the pain/problem occur at a specific time? Is it rare, intermittent, or constant? What were you doing at the onset of this pain/problem?

Associated signs/symptoms _____
What other associated problems are you having? (numbness, bladder/bowel complaints, abnormal sounds – cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain)

Modifying factors _____
What makes the pain/problem worse or better? (activities)

Have you seen any other physicians regarding **this** condition prior to coming to our office? ❑ **Yes** ❑ **No**

Doctor	When	Tests	Results	Treatment

PAST HISTORY OF PRESENT ILLNESS:
Have you ever experienced any injury or symptoms regarding this body part? ❑ **Yes** ❑ **No**

If so, please provide details _____

Please list any hobbies/sports you enjoy: _____

Which of the above activities are you unable to perform due to your pain? _____

PAST MEDICAL HISTORY: Have you ever had any of the following? *Please check all pertinent boxes:*

❑ Aids or HIV+ ❑	❑ Bronchitis	❑ Hepatitis	❑ Mumps	❑ Thyroid Disease
❑ Anemia	❑ Chicken Pox	❑ High Blood Pressure	❑ Pneumonia	❑ Tuberculosis
❑ Arthritis	❑ Diabetes	❑ Infectious Mono	❑ Polio	❑ Ulcer
❑ Asthma	❑ Diphtheria	❑ Kidney Disease	❑ Rheumatic Fever	❑ Venereal Disease
❑ Back Trouble	❑ Epilepsy/Seizures	❑ Low Blood Pressure	❑ Scarlet Fever	❑ Whooping Cough
❑ Bladder Infections	❑ Glaucoma	❑ Measles	❑ Sleep Apnea	❑ Other (please list)
❑ Bleeding Tendency	❑ Heart Disease	❑ Migraine Headaches	❑ Smallpox	_____
❑ Blood Transfusions	❑ Hemorrhoids	❑ Mitral Valve Prolapse	❑ Stroke	

PLEASE COMPLETE OTHER SIDE

Medications: Include non-prescription & Herbal Supplements

Drug Name	Dosage	Frequency

Allergies:

Medication	Reaction

Tape Allergy ❑ Yes ❑ No **Latex Allergy** ❑ Yes ❑ No

Past Surgical/Hospitalization History:

Date	Surgery/Illness	Doctor	Hospital, City, State

Patient Social History:

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

Use of Alcohol
- ❑ Never
- ❑ Rarely
- ❑ Moderate
- ❑ Daily

Use of Tobacco
- ❑ Never
- ❑ Previously, but quit
- ❑ Currently

_____ Packs per day

Living Situation
- ❑ With Family
- ❑ With Friends
- ❑ Alone
- ❑ Other _____

Family Medical History:

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

Review of Systems: Please indicate any personal history below: (Please circle all that apply)

Musculoskeletal

Joint pain	No	Yes
Joint stiffness or swelling	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
Earaches 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 breath, while walking	No	Yes
Swelling of feet, ankles, or hands	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Female – number of pregnancies		
Female – number of deliveries		

Integumentary (skin, breast)

Rash or itching	No	Yes
Changes 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 sensations	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 tendency	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, blood in stool	No	Yes
Abdominal pain	No	Yes

Respiratory

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

Eyes

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

Allergic / Immunologic

List food / environmental allergies:

_____
_____
_____
_____
_____

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