SOUTHERN CALIFORNIA ORTHOPEDIC INSTITUTE - PATIENT MEDICAL HISTORY

Name: _____ **Date:** _____

Sex: **Male/Female** **Occupation:** _____

Age: **/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?

☐ 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 _____

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:

☐ 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

SOUTHERN CALIFORNIA ORTHOPEDIC INSTITUTE - PATIENT MEDICAL HISTORY

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:

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**