CALIFORNIA ORTHOPEDICS & SPINE

Medical History Form

Patient Name:_____________________________ Appointment Date:________________ with Dr. _________________

Age:_______Sex: ☐ F ☐ M Height:________ Weight:_________ Dominant hand: ☐ R ☐ L

This form is used to gather information so that my doctor can maximize the time used to examine me and answer my questions about my condition and treatment options. I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

Patient Signature (Date) Physician Signature (Date)

Have you ever been treated by this Physician? ☐ Y ☐ N

Today you are scheduled for your

Do not write in this box/For official use only

How long has this body part been a problem? Days_____ Weeks_____ Months______ Years______

In this section, check the **ONE BOX** which best describes how your problem started. Then answer the question below the box you Checked. Use as much space to the right as needed.

☐ NO INJURY (or onset was: ☐ Gradual or ☐ Sudden
Please indicate why you think it started?

☐ INJURY ☐ Accident ☐ Sport (NOT Auto or Work)
Date:________Please specify where and how it happened.
What Sport?_______________ School?________________

☐ INJURY AT WORK DATE:_________
From a: ☐ Lift ☐ Twist ☐ Fall ☐ Bend ☐ Pull ☐ Reach

☐ WORK RELATED (BUT NO INJURY)
Date:________ How did your job cause the problem?

☐ AUTO ACCIDENT Date:_______ How was your car hit?

Comments:

On a scale of 0 – 10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes and goes (intermittent)

Does your pain wake you from your sleep? ☐ Y ☐ N

Do you have: ☐ Swelling ☐ Bruises ☐ Numbness ☐ Tingling ☐ Weakness ☐ Locking/Catching ☐ Buckling/Giving Way

Since my problem started, it is: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

What makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Coughing ☐ Sneezing

Which makes your symptoms better: ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other:___________________

Have you had any of these treatments? Injection: ☐ Y ☐ N Brace: ☐ Y ☐ N Physical Therapy: ☐ Y ☐ N Cane/Crutch: ☐ Y ☐ N

What tests/scans have you had for this problem:

☐ X-Rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV) Where?________________________

Please list any surgical procedures you have had on this body part?

Procedure #1______________________ Surgeon_____________________ City____________________ Date___________

Procedure #2______________________ Surgeon_____________________ City____________________ Date___________

Please complete reverse side of this form

General Medical and Social History

Have you ever had problems with general anesthesia? ☐ Yes ☐No

Present **Medications** taken regularly: ____

____

Allergies to Medications: ____

Prior and current illnesses and injuries:____

____

List all surgeries and hospitalizations:____

____

____

Alcohol: Don't Drink:____________ Quantity Socially:__________ Quantity Daily:__________

Tobacco: Don't Smoke:___________ Smoker:________ # of Years:______ # of Packs:______

Are you currently having or have you ever had a problem with the following:

	Yes	No	Describe all "Yes" responses
Heart Disease	☐	☐	______________________
High Blood Pressure	☐	☐	______________________
Lung/Breathing Problem	☐	☐	______________________
Cancer	☐	☐	______________________
Diabetes	☐	☐	______________________
Ulcer or Stomach Problem	☐	☐	______________________
GI Bleed	☐	☐	______________________
Kidney Problem	☐	☐	______________________
Hepatitis	☐	☐	______________________
Anemia or other Blood Disorder	☐	☐	______________________
Epilepsy or Seizures	☐	☐	______________________
Anxiety/Depression	☐	☐	______________________
Arthritis/Rheumatoid Arthritis	☐	☐	______________________
Thyroid Problem	☐	☐	______________________
Other Medical Condition	☐	☐	______________________
Blood Clots/DVT/PE	☐	☐	______________________

Family History

Does your immediate family have a history of any of the following medical conditions?

	Yes	**No**	**Relationship**
Heart Disease	☐	☐	______________
High Blood Pressure	☐	☐	______________
Stroke	☐	☐	______________
Diabetes	☐	☐	______________
Cancer	☐	☐	______________