# 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 _____

## 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

## 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**