CENTRAL COAST ORTHOPEDIC MEDICAL GROUP

Medical History Questionnaire

Last Name : _____ First Name : _____ What name do you prefer to be called : _____

Age : _____ DOB : _____ / _____ / _____ Height : _____ Weight : _____ | Left or Right Handed : ☐Right ☐Left

Marital Status : M S D W | Name of spouse or significant other : _____ Number of children : _____

What IS or WAS your occupation : _____ ☐Still working ☐Retired ☐Student | Primary Language : _____

What is your living situation : ☐Live at home ☐Dorm ☐Nursing Home/Assisted Living Facility _____

Who referred you to our office : ☐Doctor _____ ☐Family/Friend _____ ☐Emergency Room _____ ☐Self

Name of Primary Care Physician : _____ Cardiologist : _____

Current Condition or Injury

For what condition are you being seen today : ☐Right ☐Left ☐ Bilateral _____

Was this condition the result of an injury : ☐Yes ☐No If yes, cause : ☐Work Related ☐Auto ☐Sports ☐Other

Please Specify : _____ If Injury, date of injury : _____

If not an injury, onset was : ☐Gradual ☐Sudden _____ days / weeks / months / years (circle which)

Pain is : ☐Sharp ☐Dull ☐Burning ☐Knife-like ☐Other _____

Other Symptoms : ☐Stiffness ☐Swelling ☐Locking ☐Catching ☐Instability ☐Night Pain ☐Loss of Motion

Have you had a prior history of injury to this area or similar symptoms : ☐No ☐Yes, When : _____

Treatment to Date : ☐Ice ☐Heat ☐Ibuprofen ☐Advil ☐Aleve ☐Rx Pain Meds ☐Tylenol ☐Physical Therapy

Diagnostic Studies (where) : ☐X-Ray _____ ☐MRI _____ ☐Other _____

Past Medical History

Have you EVER had any of the following? Please check all that apply.

Cardiovascular Disease ☐ *No history of cardiovascular disease*

☐High Blood Pressure ☐Coronary Stent ☐Heart Valve Surgery ☐Heart Attack ☐Pacemaker
☐High Cholesterol ☐Chest Pain ☐Cardioversion ☐Heart Bypass ☐ Mitral Prolapse
☐Atrial Fibrillation ☐Other : _____

Respiratory Disease ☐ *No history of respiratory disease*

☐Asthma ☐Bronchitis ☐Emphysema ☐COPD ☐Sleep Apnea
☐CPAP Machine ☐Seasonal Allergies ☐Other : _____

Gastrointestinal Disease ☐ *No history of gastrointestinal disease*

☐Hepatitis A ☐Hepatitis B ☐Hepatitis C ☐Acid Reflux ☐Esophagitis
☐Peptic Ulcer Disease ☐Liver Disease ☐Pancreatitis ☐Crohn's Disease ☐Colitis (CUC)
☐Diverticulitis ☐Gall Bladder Disease ☐Hemorrhoids ☐Other : _____

Genitourinary Disease ☐ *No history of genitourinary disease*

☐Bladder Infection ☐Kidney Infection ☐Kidney Failure ☐Prostate Enlargement ☐Prostate Cancer
☐Cervical Cancer ☐Bladder Cancer ☐Kidney Stones ☐Other :_____

Endocrine Disease ☐ *No history of endocrine disease*

☐Diabetes Type I ☐Diabetes Type II ☐Hypoglycemia ☐Insulin Injections ☐Thyroid Disease
☐Parathyroid Disease ☐Cushing's Disease ☐Osteoporosis ☐Other : _____

Neurologic Disease ☐ *No history of neurologic disease*

☐Migraine Headaches ☐Headaches,Other ☐Stroke ☐Seizure Disorder ☐Paralysis
☐Multiple Sclerosis ☐Parkinson's Disease ☐Other : _____

Psychiatric Disease ☐ *No history of psychiatric disease*

☐Depression ☐Bipolar Disorder ☐Schizophrenia ☐ADD/ADHD ☐Eating Disorder
☐Drug Addiction ☐Alcohol Addiction ☐Other : _____

Oncology/Hematology ☐ *No history of oncology/hematology disease*

☐Anemia ☐Hemophilia ☐Sickle Cell Disease ☐Leukemia ☐Lymphoma
☐AIDS/HIV Positive ☐Breast Cancer ☐Melanoma ☐Other Skin Cancer ☐Bone Cancer
☐Blood Transfusion ☐Other : _____

Musculoskeletal / Rheumatologic ☐ *No history of musculoskeletal/rheumatologic disease*

☐Fibromyalgia ☐Osteoarthritis ☐Rheumatoid Arthritis ☐Scleroderma ☐Sacroidosis
☐Ankylosing Spondylitis ☐Fracture ☐Joint Replacement ☐Herniated Disk Surgery ☐Psoriasis
☐Scoliosis ☐Other : _____

Past Surgical History

Please list all procedures you have had that required local or general anesthesia in a hospital or surgery center.

Procedure	Year	Procedure	Year
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

Have you had any reaction to local of general anesthesia during any of the above procedures? ☐Yes ☐No

If yes, what was the reaction : _____

Have any blood relatives had any reaction to local or general anesthesia such as high fevers? ☐Yes ☐No

If yes, what was the reaction : _____

Please list the name and location of the pharmacy you use : _____

Current Medications

Medication Name	Dosage (mg)	Times/Day	Prescribing Doctor	Year Onset	Reason Used
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Allergies to Medications/Other (please circle)

Medication/Substance	Reaction	Medication/Substance	Reaction
Penicillin		*Novocaine*	
Tetracycline		*Aspirin*	
Codeine		*Sulfa*	
Vicodin		*Latex*	
Metals		*X-ray Contrast*	
Bee Stings		*Other*	

Family Medical History

☐Unknown, adopted

	If Living		If Deceased	
	Age	**Major Medication Conditions**	**Age**	**Cause of Death**
Father				
Mother				
Brother(s)				
Sister(s)				

Review of Symptoms

Circle all symptoms that you have had in the last six months.

Constitutional	unexpected weight loss weight gain Fever Chills Fatigue
Eyes	corrective lenses blurred vision eye pain redness watering
Ear, Nose, Throat	difficulty swallowing nose bleeds ringing in ears earaches sore throat hoarseness
Cardiovascular	chest pain palpitations fainting murmurs shortness of breath
Respiratory	wheezing cough tightness snoring inspiration pain
Gastrointestinal	heartburn nausea vomiting constipation diarrhea bloody/tarry stools difficulty swallowing
Genitourinary	frequency urgency difficult/painful urination flank pain bleeding
Musculoskeletal	joint pains swelling instability stiffness redness heat muscle pain
Skin	skin changes poor healing rash itching redness
Neurologic	headache numbness/tingling unsteady gait dizziness tremors seizures
Psychiatric	nervousness anxiety depression hallucinations
Hematologic	easy bleeding bruising bleeding gums light headedness
Endocrine	excessive thirst excessive urination heat/cold intolerance
Allergic	reactions to foods or environment such as rash shortness of breath wheezing

Do you smoke cigarettes or cigars? ☐Yes ☐No If yes, how much? _____ packs/day How many years? _____
If you no longer smoke, when did you quit? _____ How much did you smoke? _____ packs/day for _____ years.
Do you drink alcohol? ☐Yes ☐No If yes, how many drinks/day? _____ drinks/week? _____ How many years? _____
Have you ever used illicit street drugs? ☐No ☐Current ☐Past Which ones? _____
Have you ever been tested for Hepatitis? ☐Yes ☐No If yes, when? _____ What was the result? _____
For female patients, are you pregnant? ☐Yes ☐No

Ethnicity : ☐Hispanic ☐Non-Hispanic ☐Unknown ☐Decline to Answer
Race : ☐American Indian ☐Alaskan Native ☐Asian ☐Black or African-American ☐Native Hawaiian
☐Other Pacific Islander ☐White ☐Unknown ☐Decline to Answer

Thank you for taking the time to complete this form.
This information will allow your physician to consider your entire medical history in the course of his treatment of your orthopedic condition.

Patient Signature _____ **Date Signed** _____

Physician's Initials _____ Date _____