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L.A. Orthopedic Institute

Medical History

Patient Name: _____ Age_____ Date: ____/____/____

Please fill out this medical history form as accurately and completely as you can. By doing so, we will be able to spend more time discussing your problem (If more space is needed for your answers, please use page 7)

1. Describe the problem that brings you to see us:_____

_____

_____

2. Describe when and how the problem began:_____

_____

_____

3. Please list any treatments or operations you may have had for this problem:

Date	**Treatment/Surgery**	**Doctor**	**Hospital/Location**

_____

_____

_____

4. Describe any complications of problems associated with the treatment or surgeries listed above:

_____

_____

_____

5. List other doctors you have seen for this problem:

Doctor	**Approximately when**	**Hospital/City**

_____

_____

_____

_____

_____

6. Please list any other operations you have had (not listed in #3)

Date	**Surgery**	**Hospital/City**

7. Please check (☑) all current, chronic or past medical conditions.

_____Glaucoma
_____Cataracts
_____Iritis
_____Skin Cancer
_____Melanoma
_____Diabetes
_____Underactive Thyroid
_____Overactive Thyroid
_____Deep Vein Thrombosis or Blood Clots
_____Pulmonary Embolism
_____Bronchitis
_____COPD
_____Asthma
_____Emphysema
_____Pneumonia
_____Sleep Apnea
_____Mitral Valve Prolapse
_____Heart Surgery
_____Atrial Fibrillation
_____Acute MI or Heart Attack
_____Hypertension or high blood pressure
_____Congestive Heart Failure
_____Pacemaker
_____Cirrhosis
_____Hepatitis
_____Ulcer Disease
_____Castritis
_____Gastroesophageal reflux
_____Diverticulosis
_____Colon Polyps
_____Irritable Bowel Syndrome
_____Ulcerative Colitis
_____Crohn's Disease
_____Gallstones
_____GOUT
_____Rheumatoid Arthritis
_____SLE or Lupus
_____Bleeding Tendency
_____Hemophilia
_____Enlarged Prostate
_____Kidney Stones
_____Seizures
_____Stroke or CVA
_____HIV or AIDS
_____Depression
_____Cancer (specify)_____
___

8. Please list any medications you are currently taking (including dose & frequency).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

9. List any **ALLERGIES** to medications, food, latex or tape: ☐ **NO ALLERGIES**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

10. Do you now or did you smoke? ☐ Yes ☐ No packs per day____# of years_____ years you quit_____

Do you now or did drink alcohol? ☐ Yes ☐ No _____ # of years_____ years you quit_____

Have you used recreational drugs? ☐ Yes ☐ No which drug(s)_____

Have you used intravenous drugs? ☐ Yes ☐ No which drug(s)_____

Do you drink coffee and/or tea? ☐ Yes ☐ No cups per day_____

11. Religious preference:_____

12. Do you have religious restrictions against receiving blood transfusions? ☐ Yes ☐ No

13. Hobbies and Interests:_____

_____

_____

14. Occupation: _____
Duties: _____

15. Do you have an:

☐ Advanced Directive ☐ Living Will ☐ Durable power of attorney for health care

(PLEASE PROVIDE US A COPY)

16. Marital Status:

☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Children: ☐ Yes ☐ No How many: _____
Grandchildren: ☐ Yes ☐ No How many: _____

17. Family History

	Alive	Deceased	Age | Age at Death	Medical History, Conditions or Cause of Death
Paternal Grandfather	☐	☐	_____	_____
Paternal Grandmother	☐	☐	_____	_____
Maternal Grandfather	☐	☐	_____	_____
Maternal Grandmother	☐	☐	_____	_____
Father	☐	☐	_____	_____
Mother	☐	☐	_____	_____
Brother | Sister (Circle)	☐	☐	_____	_____
Brother | Sister (Circle)	☐	☐	_____	_____
Brother | Sister (Circle)	☐	☐	_____	_____
Brother | Sister (Circle)	☐	☐	_____	_____
Brother | Sister (Circle)	☐	☐	_____	_____
Son | Daughter (Circle)	☐	☐	_____	_____
Son | Daughter (Circle)	☐	☐	_____	_____
Son | Daughter (Circle)	☐	☐	_____	_____
Son | Daughter (Circle)	☐	☐	_____	_____
Son | Daughter (Circle)	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____
_____	☐	☐	_____	_____

18. Name, address and phone number of your regular doctor (General Practioner, Family Medicine, Internal Medicine)_____
_____
_____

19. Name, address and phone number of the physician who referred you (if different from above)

_____

_____

_____

20. Review of systems: Check (☑) if you have had any of the following symptoms or diseases.

GENERAL
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Frequent or recent fever
- ☐ Chills
- ☐ Fatigue
- ☐ Appetite
- ☐ Night sweats

DENTAL
- ☐ Do you need dental surgery
- ☐ Recent or ongoing dental treatment
- ☐ Tooth pain or sensitivity
- ☐ Cracked Teeth

EYES
- ☐ Blurred vision
- ☐ Loss of vision
- ☐ Eye pain
- ☐ Discharge of eye(s)
- ☐ Frequent eye infections

EARS, NOSE & THROAT
- ☐ Hay fever
- ☐ Ear Pain
- ☐ Frequent ear infections
- ☐ Discharge from ear(s)
- ☐ Frequent nosebleeds
- ☐ Nasal Discharge
- ☐ Sinus problems
- ☐ Difficulty swallowing
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Bleeding gums
- ☐ Swollen gland(s)
- ☐ Non-healing sore(s) in mouth

CARIO-RESPIRATIORY
- ☐ Cough
- ☐ Coughing up sputum
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chest pain
- ☐ Palpitations

GASTROINTESTINAL
- ☐ Hernia(s)
- ☐ Gallbladder problems
- ☐ Abdominal pain or heartburn
- ☐ Hemorrhoids
- ☐ Esophageal reflux
- ☐ Black stools
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Jaundice
- ☐ Vomiting blood
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation

GENITO-UINARY
- ☐ Burning on urination
- ☐ Frequency of urination
- ☐ Getting up at night to urinate
- ☐ Decrease in force of urinary stream
- ☐ Loss of urine with cough or sneezing
- ☐ Blood in urine
- ☐ Venereal disease(s)

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Back pain
- ☐ Disc problems
- ☐ Joint replacement
- ☐ Joint injuries
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Cold or numb feet
- ☐ Muscle weakness
- ☐ Pain which prevents sleep
- ☐ Fractures
- ☐ Varicose veins
- ☐ Leg ulcers
- ☐ Leg pain
- ☐ Leg cramps

SKIN
- ☐ Rashes
- ☐ Non-healing sore(s)

☐ Irregular pulse
☐ Tuberculosis
☐ Angina
☐ Heart murmur

NEURO-PSYCHAIATRIC

☐ Headaches
☐ Convulsions or seizures
☐ Paralysis
☐ Numbness or tingling
☐ Dizziness
☐ Insomnia
☐ Depression
☐ Personality changes
☐ Phobias
☐ Moodiness
☐ Polio
☐ Fainting spells
☐ Stroke
☐ Tremor(s)
☐ Memory loss
☐ Previous psychiatric diagnosis or treatment

ENDOCRINE

☐ Low blood sugar
☐ High blood sugar
☐ Radiation to neck or tonsils

MALES ONLY

☐ Lump(s) in testicle(s)
☐ Difficulty in starting urine
☐ Prostate problems
☐ Undescended testicle(s)
☐ Impotence

Date of last prostate exam_____
☐ Normal
☐ Abnormal

☐ Hives
☐ Changes in color or shape of mole(s)

HEMATOLOGY

☐ Anemia
☐ Easy bruising
☐ Bleeding
☐ History of transfusion(s)
☐ Transfusion reactions
☐ Problems with healing of cuts
☐ Problems with healing after surgery

MISC.

☐ Measles
☐ Mumps
☐ Scarlet fever
☐ German measles
☐ Rheumatic fever
☐ Chicken pox
☐ Contact with blood or bodily fluids

FEMALES ONLY

☐ Menopausal
☐ Vaginal discharge or infection
☐ Pelvic pain
☐ Lump(s) in breast(s)

Age at onset of menstruation_____
Date of last menstrual period_____
Total number of pregnancies_____
Abortion(s) _____
Miscarriage(s) _____
Live birth(s) _____
Date of last mammogram_____
☐ Normal
☐ Abnormal
Date of last Pap Smear_____
☐ Normal
☐ Abnormal

NOTES

IF MORE SPACE IS NEEDED, INDICATE QUESTION # AND CONTINUE ANSWERS.