ORTHOPEDIC MEDICAL GROUP OF SAN DIEGO INC.
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Health History Questionnaire

Patient Name______________________________________Date of Birth____________________
(please print)

Chief Complaint: What brings you in to see us today? ______________________________

History of Present Illness:

Where is the location of the problem?____

When did the problem start?____

Was there a specific injury that caused the problem? Yes / No If yes, please describe:
____

Please describe the quality of the discomfort and/or pain that you are experiencing (check all that apply): Sharp____, Dull____, Throbbing____, Burning____, Shooting____.

On a scale of 1 to 10, with 10 being the worst, how bad is your pain?
At rest:____ At its worst:____

Are there any other symptoms associated with your pain? (check any that apply):
Locking____, Catching____, Giving out____, Tingling____, Lack of sensation (numbness)____, Other (please describe)______________________________.

What, if anything, makes symptoms better?____

What, if anything, makes symptoms worse?____

What treatments, if any, have you already tried for this problem?
____

Patient Name___________________________________

Past Medical History:

If you currently have, or ever have had, any of the following medical problems, please check yes and explain:

___Yes ___No Heart disease
___Yes ___No Angina or heart-related chest pain
___Yes ___No High cholesterol
___Yes ___No Irregular heart beat or arrhythmia
___Yes ___No Thyroid disorder
___Yes ___No Liver problems, cirrhosis or hepatitis
___Yes ___No Lupus or rheumatoid arthritis
___Yes ___No Lung disease (asthma, emphysema or COPD)
___Yes ___No Stomach ulcers, digestive problems or GERD

___Yes ___No High blood pressure
___Yes ___No Diabetes
___Yes ___No Stroke
___Yes ___No Tuberculosis
___Yes ___No Anemia
___Yes ___No Epilepsy or seizures
___Yes ___No HIV or AIDS

Other_____________________________________ Height________Weight__________

Please list any active problems for which you are currently under a doctor's care:
____

Primary Care Physician Name: ____

Review of Systems: Are you currently having any of the following: **(Circle all that apply)**

Yes/No Fever, Chills, Weight gain/loss, Fatigue
Yes/No Chest pain, calf pain, blood clots
Yes/No Difficulty hearing, nose problems, snoring
Yes/No Incontinence, Rash, itching
Yes/No Coughing, wheezing, shortness of breath, coughing up blood
Yes/No Abdominal Pain, GERD, Heartburn
Yes/No Swollen glands, lymph node pain
Yes/No Seizures, Stroke, Headaches, Loss of Consciousness, Trauma
Yes/No Itching,Hives

Past Surgical History: Please list any surgeries you have had:

Procedure____________________________Year_____ Procedure________________ Year______
Procedure____________________________Year_____ Procedure________________ Year______
__I have never had a surgery

Family History:

Is your mother still alive? Yes/No If no, at what age did your mother pass away? _________
Cause of death? _________

Is your father still alive? Yes/No If no, at what age did your father pass away? ___________
Cause of death? _________

Patient Name____________________________________

Are there any other diseases which run in your family? Yes / No   If yes, please describe:____

Have any of your close relatives (siblings) passed away prematurely from a medical problem? Yes / No   If yes, please describe:___________________________________

Have any of your close relatives had any of the following problems? Blood clots/DVT/Pulmonary Embolism   Yes / No _____________________________________

Complications from anesthesia   Yes / No
Early heart disease (heart attack or stroke under age 65) Yes / No

Social History:

Are you presently working? Yes /No   What is your occupation?______________

Is your problem preventing you from working? Yes / No   If you are on disability, what is the reason for the disability?____

Do you smoke? Yes / No   If so, how much and for how long?________

How much alcohol do you typically drink?________________________________

Do you use any other drugs recreationally? Yes / No If yes, list:_____________

Are you right handed or left handed? Right/ Left   Height______ Weight__________

Allergies and Medications:
Do you have allergies to any medications? Yes / No   If yes, what is the medication & reaction:____

Patient Name____________________________________

Please list all medications you are currently taking:

Medication Name   Strength   Dosage
____
____
____

Your preferred pharmacy name ____
Pharmacy location/phone____

Patient
Signature____Date_____________________