



3905 Waring Road, Oceanside, California 92056 Phone (760) 724-9000 Fax (760) 724-3686

This form must be filled out before you see the physician. The information on the form provides basic information about your orthopaedic problem and general health condition. This information is very important and can influence your orthopaedic diagnosis and treatment.

Today's Date _____ Acct # _____ Imaging _____

Name _____ Sex M F Date of Birth _____ Age _____

Referring Doctor _____

Height _____ Weight _____ lbs Occupation _____ Dominant Hand L R

Present illness	Print answer	For medical team use
What orthopaedic problem are you being seen for today?		
When did it first occur?		
Where is the problem located? (right or left?)		
If you have pain: 1) Describe it (constant, intermittent, dull, sharp, aching, burning, shooting). 2) Rate it on a scale of 0 to 10. (0 is no pain. 10 is worst pain ever)		
What relieves the symptom?		
What makes the symptom worse?		
Have you had a similar problem before?		
What medical tests or treatment have you received for this problem?		

Other orthopaedic problems: Check any of the following that you have had. Indicate right or left and joint location, if applicable, next to the condition.

Example: Recurrent joint swelling R shoulder

- | | | | |
|---|---|---|------------------------------------|
| <input type="checkbox"/> Recurrent joint swelling | <input type="checkbox"/> Recurrent joint pain | <input type="checkbox"/> Dislocated joint | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Loose pieces in joint | <input type="checkbox"/> Joint/bone infection | <input type="checkbox"/> Bone Spurs | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Decreased joint movement | <input type="checkbox"/> Joint laxity (looseness) | <input type="checkbox"/> Brittle bones (osteoporosis) | |
| <input type="checkbox"/> Bursitis/tendonitis | <input type="checkbox"/> Torn cartilage | <input type="checkbox"/> Torn muscle/ligament/tendon | |
| <input type="checkbox"/> Neck/Back pain | <input type="checkbox"/> Ruptured disc | <input type="checkbox"/> Abnormal spine curvature | |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Chest Deformity | <input type="checkbox"/> Amputations | |

Fractures and other serious injuries:
(list location and approximate date)

Past surgeries:
(list type and approximate date)

Other surgery questions:

Have you received any blood transfusions? Yes No
(If “yes,” list year received)

Have you ever had an infection in an incision after surgery? (If “yes,” list) Yes No

Have you ever a bad reaction to anesthesia? Yes No
(If “yes,” list)

Have you or a family member ever had a bleeding problem after surgery? (If “yes,” list) Yes No

Allergies: (list drug or substance and your reaction to it)

Medications: List all medicines and herbs that you take regularly. Check bottle label for dose and time of day you take it. (See example below)

Medicine/Herb	Dose	Number of pills taken when
<i>Example: Pepcid</i>	<i>20mg</i>	<i>1 pill at 8am, 1 pill at 6pm</i>

Other Substances: Have you used any of the following substances? Check “Yes” or “No” and fill in the blanks. See example below.

Substance	Currently use?	Previously used?	Type/amount/frequency	How long (yrs)	If stopped, when? (yr)
Caffeine: coffee, tea, soda	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Beer, wine, liquor	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Recreational/ Street drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Example: Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarettes 1 pack/day	18 yrs	1979

For medical team use

Family medical history: Check any of the following conditions that your mother (M), father (F), brother (B), or sister (S) has or had. Next to the condition, indicate which family member has or had it.

Example: If your mother and sister has/had heart disease: Heart disease M, S

- | | | | |
|--|--|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Other disease _____ | | | |

Review of symptoms: Circle any symptoms or condition which you have had or now have

For medical team use

General: weight change, loss of appetite, fever, other _____

Skin: rashes, lumps, sores, change in color or size of mole, other _____

Head: headaches, head injury, other _____

Eyes: sudden loss of vision, double vision, cataracts, glaucoma, eye pain, eye redness, other _____

Ear: sudden loss of hearing, ringing in ears, vertigo, ear infections, drainage from ear, other _____

Nose and Sinuses: nosebleeds, sinus infections, other _____

Mouth and Throat: dentures, decayed teeth, bleeding gums, sores in mouth, hoarseness, difficulty swallowing, other _____

Neck: lumps in neck, swollen glands, goiter, pain or stiff neck, other _____

Breasts: lumps, nipple discharge, dimpled skin, other _____

Respiratory: recurrent cough, excessive sputum, bloody sputum, wheezing, asthma, emphysema, pneumonia, tuberculosis, positive skin test for TB, shortness of breath, sleep apnea, other _____

Cardiac: high or low blood pressure, rheumatic fever, heart attack, chest pain at rest or on exertion, irregular heart rate, swelling of both legs or ankles, sleep on two or more pillows, high cholesterol, other _____

Blood vessels in legs: leg cramps when walking, varicose veins, cold feet, sores on feet or ankles, blood clots in legs, other _____

Gastrointestinal: heartburn, recurrent nausea or vomiting, recurrent constipation or diarrhea, rectal bleeding, black stools, loss of bowel control, ulcers, hernias, abdominal pain, jaundice, liver or gallbladder problems, hepatitis, colon polyp/tumor, other _____

Urinary: frequent urination, burning on urination, recurrent bladder or kidney infections, loss of bladder control, kidney stones, decreased force of urinary stream, blood in urine, other _____

Male Genital: drainage from or sores on penis, pain or lump in testicle, prostatitis, scrotal swelling, difficulty in sexual functioning, history of sexually transmitted disease, other _____

Female Genital: Date of last menstrual period _____
age at menopause _____, complications of pregnancy, drainage from vagina, sores or lumps in or around vagina, abnormal bleeding, difficulty in sexual functioning, history of sexually transmitted disease, other _____

Nerve problems: blackouts, seizures or convulsions, paralysis, frequent or constant numbness or tingling in a body part, abnormal memory loss, tremors, history of polio or muscular sclerosis or stroke/TIA, slurred speech, other _____

Blood problems: anemia, easy bruising or bleeding, splenectomy, leukemia, other _____

Other glands: overactive or underactive thyroid, diabetes, excessive urination, sweating or thirst, enlarged lymph nodes, other _____

Emotional problems: excessive nervousness, worry, or anxiety, depression, insomnia, other _____

For medical team use

Reviewed by _____ Date _____

Re - reviewed by _____ Date _____

Re - reviewed by _____ Date _____