

# Patient Medical History

CALIFORNIA PACIFIC ORTHOPAEDICS & SPORTS MEDICINE

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_ Children: \_\_\_\_\_

I am: Left Handed Right Handed Who may we thank for your referral? \_\_\_\_\_

Are we seeing you in relation to an injury/accident? Yes No If yes: Date of Injury? \_\_\_\_\_

Automobile Accident Work-Related Injury Other \_\_\_\_\_

Are you on Disability? Yes No If yes: Last Date of Work? \_\_\_\_\_

## **Current Medical problems:**

Diabetes

Ulcer

Arthritis

Hepatitis

Chest Pain

Asthma

High Blood Pressure

High Cholesterol

Bowel Disorder

Emphysema

Heart Failure

Thyroid Disease

Cancer / Type \_\_\_\_\_

Kidney Disease

Prostate Disease

Heart Murmur

HIV

Other: \_\_\_\_\_

**1) What medications do you take routinely? (Include dosage and frequency)** \_\_\_\_\_

**2) Allergy to Medication:** \_\_\_\_\_

**3) Are you currently using intravenous or recreational drugs? (Include type and amount per day)**

**4) Past Surgeries (Include type and dates):** \_\_\_\_\_

Do you smoke now? Yes No # of packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

If you quit smoking, how long ago? \_\_\_\_\_ # of packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_

Do you drink alcohol? Yes No How many ounces per day? \_\_\_\_\_

(One 12 oz. beer or one glass of wine = 1 oz. of hard liquor)

Diet: High in fat / Cholesterol Moderate Low Vegetarian

How many times per week do you exercise? \_\_\_\_\_ What type? \_\_\_\_\_

Father: Alive Deceased Age and cause of death: \_\_\_\_\_

Mother: Alive Deceased Age and cause of death: \_\_\_\_\_

Sibling: Alive Deceased Age and cause of death: \_\_\_\_\_

Sibling: Alive Deceased Age and cause of death: \_\_\_\_\_

Are there any diseases that run in your family? \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_ Age at Menopause: \_\_\_\_\_