

**CENTRAL COAST ORTHOPEDIC MEDICAL GROUP**  
**Medical History Questionnaire**

**GENERAL INFORMATION**

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  
Number of people who live with you? \_\_\_\_\_ What is your primary language? \_\_\_\_\_  
What is your living situation?  Live at home  Dorm  Nursing home or Assisted living facility \_\_\_\_\_  
Who referred you to this office for THIS visit?  Doctor: \_\_\_\_\_  Family / Friend: \_\_\_\_\_  Self  
Were you referred by your doctor for THIS visit?  Yes  No Doctor's Name: \_\_\_\_\_  
Were you seen in the Emergency room for THIS problem?  Yes  No Which one? \_\_\_\_\_  
Name of your Primary Care Physician: \_\_\_\_\_ Name of your Cardiologist: \_\_\_\_\_  N/A  
Which doctor are you seeing today?  Devine  Fryer  Laird  Schueckler  Woods  
Have you seen this doctor before in this office?  Yes  No When? \_\_\_\_\_ For what condition? \_\_\_\_\_  
Has this doctor treated any of your family or friends?  Yes  No If so, who? \_\_\_\_\_  
Have you seen any of these doctors?  Devine  Fryer  Laird  Schueckler  Woods  Blackburn  
 Spoo  Castello  Kasper

**CURRENT CONDITION OR INJURY**

For what condition are you being seen today? \_\_\_\_\_  Right  Left  
Was this condition the result of an injury?  Yes  No If yes, cause?  Work related  Auto accident  Sports  
 Other injury Please specify \_\_\_\_\_  
If injury, Date of Injury: \_\_\_\_\_ If not, onset was  Gradual  Sudden \_\_\_\_ days / weeks / months / years ago  
Nature of symptoms: Pain is :  Sharp  Dull  Burning  Knife-life  Other \_\_\_\_\_  
Other Symptoms:  Stiffness  Swelling  Locking  Catching  Instability  Night pain  Loss of motion  
Prior history of injury to this area or similar symptoms?  No  Yes, When? \_\_\_\_\_  
Treatment to Date:  Ice  Advil  Aleve  Tylenol  Rx Pain Meds  Physical therapy  Splinting  
Diagnostic studies (where):  X-rays \_\_\_\_\_  MRI \_\_\_\_\_  Other \_\_\_\_\_

This space for use by the physician:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**CENTRAL COAST ORTHOPEDIC MEDICAL GROUP**  
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**PAST MEDICAL ILLNESSES**

*Have you ever had any of the following? Check all that apply. Please be as complete as possible.*

**Cardiovascular Disease**

No history of cardiovascular disease

High Blood Press.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Coronary stent	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart valve surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	Artificial valve	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chest pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cardioversion	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Bypass	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mitral prolapse	Yes <input type="checkbox"/> No <input type="checkbox"/>	Atrial fibrilat.	Yes <input type="checkbox"/> No <input type="checkbox"/>	High cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Respiratory (Lung) Disease**

No history of respiratory disease

Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bronchitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>
COPD	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sleep apnea	Yes <input type="checkbox"/> No <input type="checkbox"/>	CPAP machine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seasonal allergy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other_____			

**Gastrointestinal Disease**

No history of gastrointestinal disease

Hepatitis A	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis C	Yes <input type="checkbox"/> No <input type="checkbox"/>
Acid reflux	Yes <input type="checkbox"/> No <input type="checkbox"/>	Esophagitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Peptic ulcer disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Liver disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pancreatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Crohn's Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Colitis (CUC)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diverticulitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gall bladder disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hemorrhoids	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other_____			

**Genitourinary Disease**

No history of genitourinary disease

Bladder Infection	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney infection	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Failure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Prostate enlargmt	Yes <input type="checkbox"/> No <input type="checkbox"/>	Prostate cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cervical cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bladder cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Stones	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other_____	

**Endocrine Disease**

No history of endocrine disease

Diabetes Type I	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes Type II	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hypoglycemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Insulin injections	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Parathyroid disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cushing's disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Osteoporosis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other_____	

**Neurologic Disease**

No history of neurologic disease

Migrane headaches	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizure disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Headaches, other	Yes <input type="checkbox"/> No <input type="checkbox"/>	Paralysis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Multiple sclerosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Parkinson disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other_____			

**Psychiatric Disease**

No history of psychiatric disease

Depression	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bipolar disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Schizophrenia	Yes <input type="checkbox"/> No <input type="checkbox"/>
ADHD/ADD	Yes <input type="checkbox"/> No <input type="checkbox"/>	Eating disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Drug addiction	Yes <input type="checkbox"/> No <input type="checkbox"/>
Alcohol addiction	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other_____			

Name:\_\_\_\_\_

**CENTRAL COAST ORTHOPEDIC MEDICAL GROUP**  
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**Oncology / Hematology**

No history of cancer or hematologic disease

- Anemia Yes  No  Hemophilia Yes  No  Sickle cell disease Yes  No   
 Leukemia Yes  No  Lymphoma Yes  No  AIDS/ HIV positive Yes  No   
 Prostate cancer Yes  No  Breast cancer Yes  No  Cervical cancer Yes  No   
 Melanoma Yes  No  Other skin cancer Yes  No  Bone cancer Yes  No   
 Blood transfusion Yes  No  Other \_\_\_\_\_

**Musculoskeletal / Rheumatologic**

No history of musculoskeletal or rheumatologic disease

- Fibromyalgia Yes  No  Osteoarthritis Yes  No  Rheumatoid arthritis Yes  No   
 Scleroderma Yes  No  Sacroidosis Yes  No  Ankylosing Spondylitis Yes  No   
 Fracture Yes  No  Joint replcemnt Yes  No  Herniated disk surgery Yes  No   
 Psoriasis Yes  No  Scoliosis Yes  No  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.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Have you had any reaction to local or 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? \_\_\_\_\_

What pharmacy do you typically use? \_\_\_\_\_ City: \_\_\_\_\_

**CURRENT MEDICATIONS**

Medication name	Dosage (mg)	Times/Day	Doctor Rx ing	Year onset	Reason used
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Name: \_\_\_\_\_

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**ALLERGIES TO MEDICATIONS**

Please check all that apply to you  I have no known allergies to medications

- |                                     |                 |                                       |                 |
|-------------------------------------|-----------------|---------------------------------------|-----------------|
| <input type="checkbox"/> Penicillin | Reaction: _____ | <input type="checkbox"/> Tetracycline | Reaction: _____ |
| <input type="checkbox"/> Codeine    | Reaction: _____ | <input type="checkbox"/> Vicodin      | Reaction: _____ |
| <input type="checkbox"/> Novocaine  | Reaction: _____ | <input type="checkbox"/> Aspirin      | Reaction: _____ |
| <input type="checkbox"/> _____      | Reaction: _____ | <input type="checkbox"/> _____        | Reaction: _____ |

**OTHER ALLERGIC CONDITIONS**

Please check all that apply to you  I have no allergy to those listed below

- |   |                       |  |                 |
|---|-----------------------|--|-----------------|
| <input type="checkbox"/> Latex          | Reaction: _____       | <input type="checkbox"/> Metals (eg. Nickel) | Reaction: _____ |
| <input type="checkbox"/> X-ray contrast | Reaction: _____       | <input type="checkbox"/> Bee stings          | Reaction: _____ |
| <input type="checkbox"/> Foods          | What foods? _____     |  | Reaction: _____ |
| <input type="checkbox"/> Other          | What substance? _____ |  | Reaction: _____ |

**FAMILY MEDICAL HISTORY**

*The following questions concern your biologic family medical history*

Unknown, was adopted

**If Living**

**If Deceased**

	Age	Major Medical Conditions	Age	Cause of Death
Father				
Mother				
Brother(s)				
Sisters(s)				

**REVIEW OF SYMPTOMS**

*Please check all that apply. If you are currently experiencing this symptom, check CURRENT.  
 If in the past, check PAST. If this symptom is chronic, check both CURRENT and PAST.*

**General**

Never had any of the below symptoms

- |                      |  |                           |  |
|----------------------|--|---------------------------|--|
| Excessive fatigue    | <input type="checkbox"/> Current <input type="checkbox"/> Past | Fever/chills/night sweats | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Sudden weight change | <input type="checkbox"/> Current <input type="checkbox"/> Past | Loss of appetite          | <input type="checkbox"/> Current <input type="checkbox"/> Past |

**Eyes, Ears, nose, mouth, throat**

Never had any of the below symptoms

- |                       |  |                    |  |
|-----------------------|--|--------------------|--|
| Blindness             | <input type="checkbox"/> Current <input type="checkbox"/> Past | Glaucoma           | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Double vision         | <input type="checkbox"/> Current <input type="checkbox"/> Past | Blurry vision      | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Hearing loss          | <input type="checkbox"/> Current <input type="checkbox"/> Past | ringing in ears    | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Difficulty swallowing | <input type="checkbox"/> Current <input type="checkbox"/> Past | Sores mouth/tongue | <input type="checkbox"/> Current <input type="checkbox"/> Past |

**Cardiovascular**

Never had any of the below symptoms

- |            |  |                      |  |
|------------|--|----------------------|--|
| Chest pain | <input type="checkbox"/> Current <input type="checkbox"/> Past | Irregular heart beat | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Arrhythmia | <input type="checkbox"/> Current <input type="checkbox"/> Past | Ankle swelling       | <input type="checkbox"/> Current <input type="checkbox"/> Past |

Name: \_\_\_\_\_

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**Respiratory**       Never had any of the below symptoms

Shortness of breath	<input type="checkbox"/> Current <input type="checkbox"/> Past	Frequent cough	<input type="checkbox"/> Current <input type="checkbox"/> Past
Wheezing	<input type="checkbox"/> Current <input type="checkbox"/> Past	Chronic cough	<input type="checkbox"/> Current <input type="checkbox"/> Past

**Gastrointestinal**       Never had any of the below symptoms

Abdominal pain	<input type="checkbox"/> Current <input type="checkbox"/> Past	Constipation	<input type="checkbox"/> Current <input type="checkbox"/> Past
Diarrhea	<input type="checkbox"/> Current <input type="checkbox"/> Past	Bleeding rectally	<input type="checkbox"/> Current <input type="checkbox"/> Past
Vomiting blood	<input type="checkbox"/> Current <input type="checkbox"/> Past	Heartburn	<input type="checkbox"/> Current <input type="checkbox"/> Past

**Genitourinary**       Never had any of the below symptoms

Incontinence	<input type="checkbox"/> Current <input type="checkbox"/> Past	Hesitancy	<input type="checkbox"/> Current <input type="checkbox"/> Past
Burning on urination	<input type="checkbox"/> Current <input type="checkbox"/> Past	Blood in urine	<input type="checkbox"/> Current <input type="checkbox"/> Past
Hesitancy on urination	<input type="checkbox"/> Current <input type="checkbox"/> Past	Frequent urination	<input type="checkbox"/> Current <input type="checkbox"/> Past

**Miscellaneous**       Never had any of the below symptoms

Breast Mass / Lump	<input type="checkbox"/> Current <input type="checkbox"/> Past	Breast Discharge	<input type="checkbox"/> Current <input type="checkbox"/> Past
Easy bleeding	<input type="checkbox"/> Current <input type="checkbox"/> Past	Easy bruising	<input type="checkbox"/> Current <input type="checkbox"/> Past
Skin rash, bumps	<input type="checkbox"/> Current <input type="checkbox"/> Past	Skin cancers	<input type="checkbox"/> Current <input type="checkbox"/> Past
Skin lesions	<input type="checkbox"/> Current <input type="checkbox"/> Past	Skin ulcerations	<input type="checkbox"/> Current <input type="checkbox"/> Past

**Neurologic / Psychiatric**       Never had any of the below symptoms

Dizziness	<input type="checkbox"/> Current <input type="checkbox"/> Past	Balance problems	<input type="checkbox"/> Current <input type="checkbox"/> Past
Tingling in feet	<input type="checkbox"/> Current <input type="checkbox"/> Past	Tingling in hands	<input type="checkbox"/> Current <input type="checkbox"/> Past
Depression	<input type="checkbox"/> Current <input type="checkbox"/> Past	Anxiety attacks	<input type="checkbox"/> Current <input type="checkbox"/> Past

Do you smoke cigarettes?  Yes  No If yes, how much? \_\_\_\_\_ packs/day For how many years now? \_\_\_\_\_  
 If you no longer smoke, when did you quit? \_\_\_\_\_ How much did you smoke? \_\_\_\_\_ packs/day How long? \_\_\_\_\_ 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? \_\_\_\_\_  
 What do you enjoy doing in your spare time? \_\_\_\_\_  
 Have you been tested for HIV?  Yes  No If yes, when? \_\_\_\_\_ What was the result? \_\_\_\_\_  
 Have you been tested for Hepatitis?  Yes  No If yes, when? \_\_\_\_\_ What was the result? \_\_\_\_\_  
 For women patients: Are you pregnant?  Yes  No Last menstrual period? \_\_\_\_\_

***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

Name: \_\_\_\_\_

Date signed

