

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? Blackburn Castello Kasper Spoo
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:

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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: _____

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Oncology / Hematology

No history of cancer or hematologic disease

- | | | | | | |
|-------------------|----------------------------------------------------------|-------------------|----------------------------------------------------------|---------------------|----------------------------------------------------------|
| Anemia | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hemophilia | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sickle cell disease | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Leukemia | Yes <input type="checkbox"/> No <input type="checkbox"/> | Lymphoma | Yes <input type="checkbox"/> No <input type="checkbox"/> | AIDS/ HIV positive | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Prostate cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> | Breast cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> | Cervical cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Melanoma | Yes <input type="checkbox"/> No <input type="checkbox"/> | Other skin cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> | Bone cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Blood transfusion | Yes <input type="checkbox"/> No <input type="checkbox"/> | Other _____ | | | |

Musculoskeletal / Rheumatologic

No history of musculoskeletal or rheumatologic disease

- | | | | | | |
|--------------|----------------------------------------------------------|-----------------|----------------------------------------------------------|------------------------|----------------------------------------------------------|
| Fibromyalgia | Yes <input type="checkbox"/> No <input type="checkbox"/> | Osteoarthritis | Yes <input type="checkbox"/> No <input type="checkbox"/> | Rheumatoid arthritis | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Scleroderma | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sacroiodosis | Yes <input type="checkbox"/> No <input type="checkbox"/> | Ankylosing Spondylitis | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Fracture | Yes <input type="checkbox"/> No <input type="checkbox"/> | Joint replcemnt | Yes <input type="checkbox"/> No <input type="checkbox"/> | Herniated disk surgery | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Psoriasis | Yes <input type="checkbox"/> No <input type="checkbox"/> | Scoliosis | Yes <input type="checkbox"/> No <input type="checkbox"/> | 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

