Corona
Temecula
Orthopaedic
Associates
MEDICAL GROUP INC.

PATIENT MEDICAL HISTORY

Date: _____ Who sent you to our office? _____

Patient's Name: _____ SSN: _____ Sex: ☐ M ☐ F

Date of Birth: _____ Age: _____ ☐ Right-handed ☐ Left-handed Height: _____ Weight: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

CHIEF COMPLAINT

Reason for your visit: _____ Date of Injury: _____

Did you have an injury? Explain: _____ Where? _____

Current problem is the result of: (Check all that apply) ☐ Car accident ☐ Work Accident ☐ Other: _____

Is there a third-party insurer involved: ☐ Yes ☐ No Name of auto insurance: _____

Auto insurance name & address: _____

Have you had X-rays? ☐ Yes ☐ No Where: Date:

PATIENT MEDICAL PROBLEMS (CHECK ALL THAT APPLY)

☐ Diabetes
☐ Insulin Dependent ☐ Dialysis
☐ High Blood Pressure
☐ Cholesterol Problems
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Blackouts/Fainting ☐ Seizures
☐ Bleeding Disorder
☐ Cancer _____
☐ COPD
☐ Concussion(s)
☐ Depression
☐ Gastroesophageal Reflux Disease (GERD)
☐ Gout
☐ Heart Disease
☐ Heart Attack ☐ Stroke ☐ Stent ☐ Defibrillator ☐ Pacemaker
☐ Hepatitis _____
☐ Hormone Replacement Therapy
☐ Kidney Problems
☐ Lung Disease
☐ Migraines
☐ Numbness & Tingling
☐ Obesity
☐ Psychological Problems _____
☐ Repeated Infections
☐ Seasonal Allergies
☐ Sleep apnea ☐ Use CPAP
☐ Thyroid Disease
☐ **Other** _____
☐ **NO PERTINENT PAST MEDICAL HISTORY**

LIST **ALL** ALLERGIES INCLUDING MEDICATION ALLERGIES: _____

Allergy to LATEX? ☐ **Yes** ☐ **No** Allergy or reaction to metal? ☐ **Yes** ☐ **No** If yes, which? _____

FAMILY HISTORY

Has any **blood relative** had any of the following? **Please enter relationship.**

☐ Arthritis _____
☐ Anemia _____
☐ Leukemia _____
☐ Bleeding disorder _____
☐ Repeated infections _____
☐ Crippling infections _____
☐ Chronic lung disease _____
☐ Tuberculosis _____
☐ Heart Disease _____
☐ Hypertension _____
☐ Kidney disease _____
☐ Asthma _____
☐ Allergies _____
☐ Mental Illness _____
☐ Migraines _____
☐ Diabetes _____
☐ Gout _____
☐ Cancers _____
☐ Ulcers _____
☐ Thyroid problems _____
☐ Obesity _____

Patient's Initials: _____ **Reviewed by:** _____

---Please complete 2nd page ---►

SOCIAL HISTORY

☐ Employed (Occupation: _____) ☐ Work in home ☐ Student ☐ Daycare ☐ Retired

☐ Single ☐ Married ☐ Divorced ☐ Widowed Children: ☐ No ☐ Yes #_____

Do you live alone? ☐ Yes ☐ No If NO, who do you live with? ☐ Spouse ☐ Children ☐ Parents ☐ Other _____

Exercise: ☐ Daily ☐ 1-3 times/week ☐ 4-6 times/week ☐ Inactive

What type of exercise? _____

Special Interests or Hobbies: _____

Eating habits: ☐ Good ☐ Fair ☐ Poor Explain: _____

History of substance abuse: ☐ Yes ☐ No If YES, explain: _____

Smoke Currently ☐ No ☐ Yes If YES, how many a day: _____ For how many years? _____

Quit smoking: ☐ This year ☐ 1 year ago ☐ 5 years ago ☐ Longer: _____ ☐ **NEVER SMOKED**

Drink Alcohol: ☐ No ☐ Yes If YES, how much per day: _____

MEDICATIONS – PLEASE LIST CURRENT MEDICATIONS

Medication	Strength	Frequency	Reason for Medication

SURGICAL HISTORY – PLEASE LIST

Type of Surgery	Month/Year

Do you have an advanced directive, durable power of attorney for health care or living will? ☐ Yes ☐ No

If yes, may we have a copy for our records? ☐ Yes ☐ No

Any additional information: _____

_____

_____

_____

_____

Patient/Parent Signature _____ ***Date*** _____

Reviewed by: _____ Date _____