UC San Diego
MEDICAL CENTER

Name
MR#
DOB

History

Source Date

Orthopaedic Medicine

Patient Identification

Age:____ Weight:_____lbs Height:___ft___in Pain: 0---1---2---3---4---5---6---7---8---9---10
(No Pain — Mild — Moderate — Severe — worst possible)

Chief Complaint

Why are you seeing the doctor today?____

When did your pain start?____

Is your pain the result of an injury that occurred at work? ☐ Yes ☐ No

Are you currently involved in a legal case regarding your injury? ☐ Yes ☐ No

Where is the current location of your maximal pain?____

What makes the problem better?____

What makes the problem worse?____

Have you seen another doctor for this problem? ☐ Yes ☐ No

If yes: Name____

Type of doctor____

Date(s) seen____

Have you had any previous treatment for this problem? ☐ Yes ☐ No

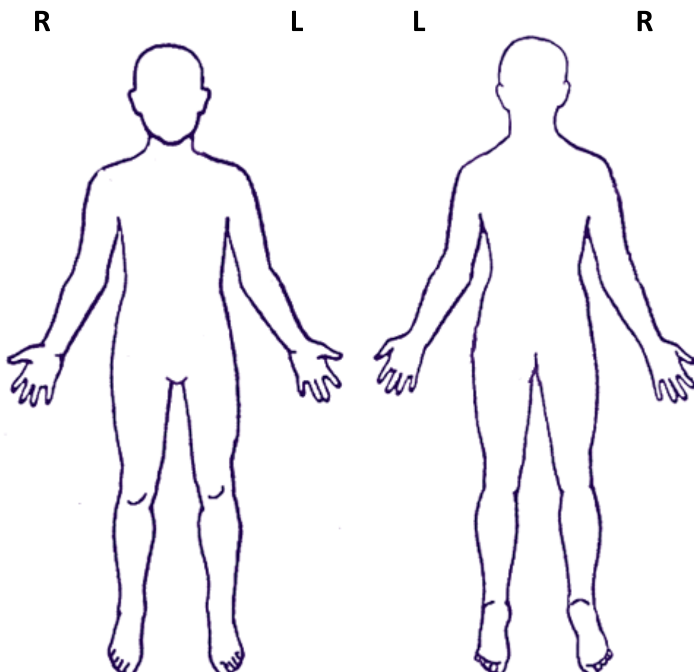
If yes, please check all that apply: ☐ Physical Therapy ☐ Medications ☐ Chiropractor ☐ Acupuncture ☐ Surgery ☐ Other______________________

Do you currently have or have you recently experienced any of the following? (please circle yes or no)

Weight Loss…….yes / no
Fever……………….yes / no
Chills……………….yes / no
Night sweats……yes / no

Weakness in arms or legs…….yes / no
Bowel problems…………………..yes / no
Bladder problems………………..yes / no
Skin or hair changes……………yes / no

Please mark the location(s) of your pain:



Please list all Medications you are taking:

1.___________________________________
2.___________________________________
3.___________________________________
4.___________________________________
5.___________________________________
6.___________________________________
7.___________________________________

Please list any allergies you may have:

1.___________________________________
2.___________________________________
3.___________________________________

Please Complete Reverse Side of This Form

Name
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Past Medical History (Please list all health problems):

1.____ 4.______________________________________
2.____ 5.______________________________________
3.____ 6.______________________________________

Surgical History (Please list all previous surgeries):

1.____ 3. ______________________________________
2.____ 4. ______________________________________

Family History:

Do you have a history of any of the following in your immediate family? (please check all that apply):

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Other

If yes, please explain:____

Is there any history of any neuromuscular diseases in your family? ☐ Yes ☐ No

If yes, please explain:____

Social History: Please check the following:

Employment: ☐ Employed (occupation_______________________) ☐ Work at Home
☐ Student ☐ On disability ☐ Other____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children: ☐ Yes ☐ No # of children__________

Do you live alone? ___Yes ___No
Exercise: ___daily ___>1/week ___weekly ___monthly ___rarely ___never
What type of exercise?____
Are you on a special diet? ___Yes ___No If yes, explain:____
History of substance abuse: ___Yes ___No If yes, explain:____
Currently Smoking: ___Yes ___No Packs per day_____________ Years?_____________
Quit Smoking: ___This year ___> 1 year ___> 5 years ___>10 years
Previously Smoked? Packs per day_______________ Years?_______________
Drink Alcohol? ___Daily ___1 -2 x week ___1-2 x month ___1-2 x year

Review of Systems: Are you currently or have you had problems with:

	Yes	No		Yes	No
Eyes, Ears, Nose, Throat	___	___	High Blood Pressure	___	___
Lungs, breathing	___	___	Cancer	___	___
Swallowing, digestion	___	___	Tuberculosis	___	___
Bleeding problems	___	___	Psychological Problems	___	___
Heart	___	___	Seizures	___	___
Sexual dysfunction	___	___	Infection	___	___

If you answered yes to any of the above, please explain____
____