West Coast Center for Orthopaedic Surgery
and Sports Medicine
1200 Rosecrans Avenue, Suite 208
Manhattan Beach, CA 90266
Phone: (310) 416-9700
Fax: (310) 416-1144

MEDICAL HISTORY SCREENING FORM

Patient Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

Referred by:_____ _____ Primary care physician/Internist: _____

Height: _____ Weight: _____ Orthopedic surgeon: _____

MARITAL STATUS:

❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widow/Widower

LIVES WITH: (SOCIAL HISTORY):

❑ Alone ❑ Spouse ❑ Family ❑ Friends ❑ L/I Nursing Home ❑ Retirement Home ❑ Other: _____

WORK STATUS (SOCIAL HISTORY):

Occupation: _____ Last date worked? _____ or ❑ N/A

❑ Not currently working ❑ Currently working ❑ Disabled If yes, how? _____ ❑ Retired ❑ Unemployed

❑ Work w/ restrictions ❑ yes ❑ no If yes, details please._____

❑ Left-handed ❑ Right-handed ❑ Ambidextrous

PERSONAL HABITS:

Cigarettes: ❑ No ❑ Yes pks/day_____ or cig/day _____Alcohol: ❑ No ❑ Yes If yes, how much? ❑ Often ❑ socially ❑ Occasionally ❑ Rarely
Chew tobacco : ❑ No ❑ Yes, How many times a day? _____ Pipe: ❑ No ❑ Yes # cigars/day_____

Illegal Drug use: ❑ No ❑ Yes, If yes, drug name_____

Over the counter medications _____

Vitamins _____

HISTORY OF PRESENT ILLNESS:

Reason for visit? _____

How and when did the problem start? _____

_____

EVALUATION OF PAIN/DISCOMFORT:

What activities are you unable to do because of the pain? _____

_____

Does the pain keep you awake at night? ❑ No ❑ Yes If yes, please give details. _____

_____

What makes it feel better? _____

What makes it feel worse? _____

Pain scale (circle one number) **No Pain 1 2** (mild) **3 4 5 6 7 8**(moderate) **9 10 Severe pain** (severe)

PATIENT NAME: _____ Today's Date: _____

PREVIOUS TREATMENT FOR THIS PROBLEM:

What other physicians have you seen for this problem: _____

What prescriptions are you using presently? _____

Any physical therapy? ❑ No ❑ Yes If yes, name and date: _____

Any chiropractic care? ❑ No ❑ Yes If yes, name and date: _____

Other treatments? _____

Use of assistive devices for this problem? ❑ Cane ❑ Splints ❑ Braces ❑ Walker ❑ Other: _____

Is this being covered by Workmen's Compensation? ❑ No ❑ Yes Date of Injury: _____

Is this being covered by Auto Insurance (MedPay)? ❑ No ❑ Yes Date of Injury: _____

Is there a lawsuit or litigation pending in regard to your injury? ❑ No ❑ Yes

Attorney Name: _____

Address: _____

PAST MEDICAL HISTORY: (Please check all that apply. If you do not have anything to mark or add please select NONE)

- ❑ AIDS/HIV
- ❑ Asthma
- ❑ Bladder Disease
- ❑ Bleeding Disorder
- ❑ Heart Attack
- ❑ Heart Disease
- ❑ Cancer If so, where? _____
- ❑ Parkinson's Disease
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Gastroesophageal Reflux Disease (GERD)
- ❑ Gastrointestinal Disease
- ❑ Glaucoma
- ❑ Gout
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Multiple Sclerosis (MS)
- ❑ Hepatitis
- ❑ Hodgkin's Disease
- ❑ Hypertension (High BP)
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Irregular Heartbeat
- ❑ Kidney Disease
- ❑ Seizure Disorder
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Parathyroidism
- ❑ Pneumonia
- ❑ Prostate Disease
- ❑ Rheumatoid Arthritis
- ❑ Blood Clots (DVT)
- ❑ Bronchitis
- ❑ Heart Murmur
- ❑ Currently Pregnant
- ❑ Vascular Disease (circulation)
- ❑ Other (describe): _____

❑ **NONE**

ANY current infections, open sores or open wounds? ❑ No ❑ Yes, If so, where? _____

PRIOR SURGERIES: (Please mark all that apply. If there are no prior surgeries, please select NONE)

- ❑ Appendectomy
- ❑ Arthroscopy: If so, where? _____
- ❑ Ankle Repair
- ❑ Carpal Tunnel Release
- ❑ Menisectomy
- ❑ Labrum Repair
- ❑ Cholecystectomy (gallbladder)
- ❑ Colonoscopy
- ❑ Coronary Artery Bypass Graft (CABG)
- ❑ D&C (Dilation & Curettage)
- ❑ Endoscopy
- ❑ Gastric Bypass
- ❑ Bicep Tendon Repair
- ❑ Hernia Repair
- ❑ Knee Replacement
- ❑ Hip Replacement
- ❑ Wrist Repair
- ❑ Laminectomy
- ❑ Pacemaker Insertion
- ❑ Rotator Cuff Repair
- ❑ ACL Repair
- ❑ Shoulder Repair
- ❑ Stent Placement
- ❑ Achilles Tendon Repair
- ❑ Scope Subtalar
- ❑ Peroneal Tendon Repair
- ❑ Other: _____

❑ **NONE**

If any of the above have been marked please provide the date of surgery (ies): _____

PRIOR FRACTURES: (Please write down what fractures you have had in the past. If there are NOT any fractures, please select NONE)

_____

_____

❑ **NONE**

PATIENT NAME: _____ Today's Date: _____

FAMILY HISTORY: (Please mark all that apply. If you have nothing to select or add, please select NONE)

- ❑ Bleeding Disorder
- ❑ Kidney Disease
- ❑ Prostate Disease
- ❑ Cancer: If so, where? _____
- ❑ Musculoskeletal Disease
- ❑ Thyroid Disease
- ❑ Diabetes
- ❑ Osteoarthritis
- ❑ Hypertension
- ❑ Heart Disease
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Other: _____

❑ **NONE**

REVIEW OF SYSTEMS: (Please mark all that apply. Mark NONE under EACH section if no symptoms are selected):

Constitutional:

- ❑ Anorexia
- ❑ Anxiety
- ❑ Body aches
- ❑ Fainting
- ❑ Fever
- ❑ Fatigue
- ❑ Fever
- ❑ Loss of appetite
- ❑ Seizures
- ❑ Sweats
- ❑ **NONE**

Comments: _____

Cardiovascular (CV):

- ❑ Angina
- ❑ Breathing, painful
- ❑ Coronary Artery Disease (CAD)
- ❑ Congestive Heart Failure (CHF)
- ❑ Chest pain
- ❑ Chest discomfort
- ❑ Chest tightness
- ❑ Dizziness
- ❑ Dyspnea (difficulty breathing)
- ❑ High blood pressure
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Shortness of breath (SOB)
- ❑ **NONE**

Comments: _____

Genitourinary (GU):

- ❑ Bladder infection
- ❑ Burning with urination
- ❑ Frequency
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Retention
- ❑ Urgency
- ❑ UTI (urinary tract infection) frequency: _____
- ❑ **NONE**

Comments: _____

Ears, Nose, Mouth & Throat (ENMT):

- ❑ Allergies
- ❑ Obstructed Breathing
- ❑ Bloody Nose
- ❑ Polyps
- ❑ Congestion
- ❑ Sinus Pain
- ❑ Frequent Colds
- ❑ Frequent Colds
- ❑ Stuffy Nose
- ❑ Mouth Breathing
- ❑ Ulcers
- ❑ **NONE**

Comments: _____

Respiratory:

- ❑ Bronchitis
- ❑ Respiratory Disease
- ❑ Emphysema
- ❑ Tuberculosis
- ❑ Pneumonia
- ❑ Wheezing
- ❑ Sleep apnea
- ❑ **NONE**

Comments: _____

Gastrointestinal (GI):

- ❑ Abdominal pain
- ❑ Abdominal swelling
- ❑ Bloody stools
- ❑ Bloody stools
- ❑ Bowel movement, painful
- ❑ Colon cancer, family history
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas/bloating
- ❑ GERD (gastroesophageal reflux disease)
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ IBS (irritable bowel syndrome)
- ❑ Indigestion
- ❑ Nausea
- ❑ Ulcer disease
- ❑ Urinary incontinence
- ❑ Vomiting
- ❑ **NONE**

Comments:

PATIENT NAME: _____ Today's Date: _____

REVIEW OF SYSTEMS continued: (Please mark all that apply. Mark NONE under EACH section if no symptoms are selected)

Musculoskeletal:

- ❑ Ambulatory dysfunction
- ❑ Arthritis
- ❑ Back pain
- ❑ Back stiffness
- ❑ Balance, (poor)
- ❑ Deformities
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Herniated disc
- ❑ Joint pain
- ❑ Joint, red and hot
- ❑ Joint stiffness
- ❑ Leg swelling
- ❑ Numbness
- ❑ Paresthesia
- ❑ Rheumatoid arthritis
- ❑ Varicose veins
- ❑ Tremors
- ❑ **NONE**

Comments: _____

Hematologic/Lymphatic:

- ❑ Bleeding/clotting disorder
- ❑ Blood disease
- ❑ Sickle cell anemia
- ❑ Easy bleeding
- ❑ Easy bruising
- ❑ Radiation treatment of any kind
- ❑ **NONE**

Comments: _____

Skin:

- ❑ Basal cell carcinoma
- ❑ Birthmarks
- ❑ Bruising
- ❑ Eczema
- ❑ Latex allergy
- ❑ Sneezing
- ❑ Rash/Rashes
- ❑ Raynaud's
- ❑ Shingles
- ❑ Sores
- ❑ Squamous cell carcinoma
- ❑ Tattoo
- ❑ **NONE**

Comments: _____

Nails:

- ❑ Cracking
- ❑ Peeling
- ❑ NONE

Comments: _____

Neurological:

- ❑ Amnesia
- ❑ CVA (cerebrovascular accident)
- ❑ Blackout
- ❑ CVA (cerebrovascular accident)
- ❑ Depression
- ❑ Disorientation
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Stroke
- ❑ TIA (transient ischemic attack)

Comments: _____

Psychiatric:

- ❑ Anxiety
- ❑ Crying frequently
- ❑ Insomni
- ❑ Memory loss
- ❑ Mood changes
- ❑ OCD
- ❑ Psychiatric treatment
- ❑ **NONE**

Comments: _____

Allergy/Immunologic:

- ❑ Allergies If yes, What: _____
- ❑ Food allergy
- ❑ Nasal
- ❑ Asthma
- ❑ Chills
- ❑ Coughing
- ❑ Diarrhea
- ❑ Difficulty breathing
- ❑ Difficulty swallowing
- ❑ Fever
- ❑ Hives
- ❑ Itchy skin
- ❑ **NONE**

Comments: _____

Hair:

- ❑ Alopecia(loss of hair)
- ❑ Increased hair growth
- ❑ **NONE**

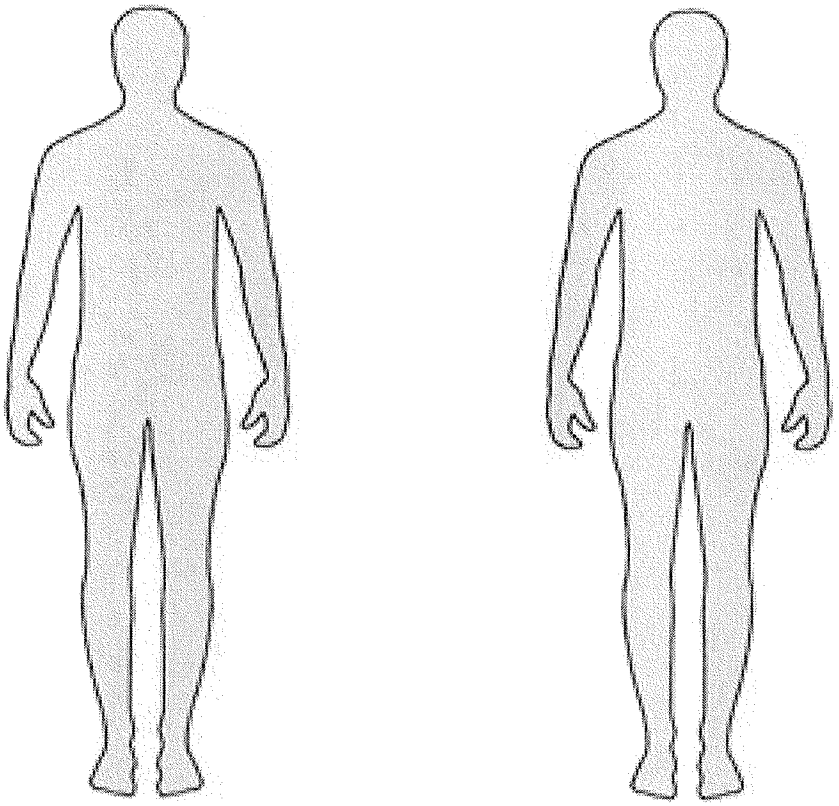
Comments: _____

Signature of Patient or Responsible Party Printed Name Date

Draw location of your pain in body outlines below and indicate how bad it is by putting the number from 1 to 10 in the area of the pain. (1 being mild and 10 being extreme)

INDICATE CONDITION IN THE APPROPRIATE AREAS ON THE DIAGRAM

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
*****	^^^^^	+++++	#####	/////	xxxxx



FRONT BACK

Has your condition been aggravated or is there a new condition? ❑ Yes ❑ No

Please explain _____

_____

What feels better today? _____

_____