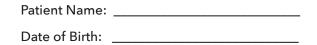


## GOLDEN STATE ORTHOPEDICS & SPINE

#### **HEALTH HISTORY**

PLEASE COMPLETE TH	E FOLLOWIN	IG INFOR	RMATION FO	R REVIEW BY	YOUR PE	ROVIDER.		
Name:				_ Birth Date	e:/	/	Age	e:
	ht: Weight:			1				Left
Referring Provider:				Occup	oation:			
Email:			Phone:					
PATIENT MEDICAL HIST	TORY (mark al	l that apply	y)					
Acid Reflux	Depression		Hepatitis		Osteoporosis		Anemia	
☐ AIDS/HIV	Diabetes		☐ High Blood Pressure		Sleep	Apnea	☐ Enlarged Prostate	
Arthritis	 Drug Abuse		☐ Irregular Heart Beat		Liver	Disease	☐ Heart Disease	
Bleeding Disorder			☐Kidney Disease		Thyro	oid Disease	Other:	
Cancer	 ☐ Fibromyalgia		Lung Disease		Heart Attack			
Type & Year	Gout		COPD		Strok	e		
	Atrial Fib	rillation	Seizure [	Disorder	Asthr	ma		
PREVIOUS SURGERIES	& DATE(S):			NONE				
1.				2.				
3.				4.				
5.				6.				
IS INJURY WORK RELA	TED?	Yes 🗌 🏻	No If y	es, have you	filed a wo	ork comp cla	aim?	
FAMILY MEDICAL HISTO	<b>ORY</b> (Mark if y	our immea	liate family mer	mbers (mom, d	ad, sibling	s) have any o	f these condi	tions)
Alcoholism B	Bleeding [	Diabet	es 🗌 Hea	art Disease	[	☐ Kidney D	isease	Seizures
Arthritis	Cancer [	Gout	Hig	h Blood Pres	sure [	Mental III	ness	Stroke
DO YOU EXERCISE REC	GULARLY?	Yes	□ No □	escribe:				
TOBACCO USE:		Yes	□ No □	escribe:				
ALCOHOL CONSUMPTION:		Yes	□ No If	No If Yes: □ Daily □ Weekly □ Occasionally □ Socia				
RECREATIONAL/DRUG USE: [		Yes	□ No T	No Type/Amount/Frequency:				
ALLERGIES: (If yes, please list)		☐ Yes	□No					
Latex Allergy/Sensitivity		Yes	□No					
Metal Allergy		Yes	□No					
Shellfish Allergy		☐ Yes	□No					
Medication/Food Alle		Allergic	Reaction					





## GOLDEN STATE ORTHOPEDICS & SPINE

#### **HEALTH HISTORY, CONTINUED**

REVIEW OF SYMPIC	JMS (Recent or cu	rrent conditio	ns only)					
Constitutional		Cardiovas	cular	Inte	Integumentary		Metabolic/Endocrine	
NONE	NONE Chills		☐ NONE ☐ Chest Pain		NONE		NONE	
Fever	Fever Fatigue		Heart Murmur		☐ Itchy Skin		Hair Loss	
☐ Night Sweats	Malaise	☐ Irregular	☐ Irregular Heart Beat		Rash		☐ Heat Intolerant	
☐Weakness		☐ Heart Pa	lpitations	□ SI	kin Infections		Col	d Intolerant
☐ Weight Gain		Leg Swe	lling	SI	kin Lesions			
☐ Weight Loss		Fainting		□С	ontact Allerg	у		
Head, Eye, Ear, Nos	e & Throat	Gas	Gastrointestinal		Neurological			Psychiatric
NONE	NONE Vertigo		NONE		NONE			NONE
☐ Blurred/Double Vis	ion Uision Lo	oss $\square$ A	Abdominal Pain		$\square$ Difficulty Walking			Anxiety
☐ Difficulty Swallowin	ıg		☐ Constipation		Dizziness			Depression
Ear Drainage	Hematolo	gic 🗆 F	requent Constipatio	n	Poor Co	ordination		☐Insomnia
☐ Facial Pain	□NONE	□ F	leartburn		☐ Memory	Loss		
Headache	Bleeding	J 🗆 J	aundice		☐ Muscle \	Weakness		Reproductive
☐ Hearing Loss	Bruising		oss of Appetite		Tremors			NONE
☐ Nasal Congestion			Nausea		$\Box$ Tingling			☐ Pregnant
Ringing in Ears			omiting/					
Respiratory		Genit	tourinary			Immunol	logical	
NONE		□NC	NE					
☐ Cough		☐ Dy	rsuria (Painful Urina	ation)	ion) Asthma			
Dyspnea (Difficulty Breathing)			☐ Frequent Urination			Contact Dermatitis		
Recent Infections	;	□ He	ematuria (Blood in	Urine	e)	☐ Enviro	onmen	tal Allergies
☐ Known TB Expos	ure	Uı	ge Incontinence			☐ Food	Allergi	es
Wheezing		☐ Uı	rinary Incontinence	9		Seaso	nal All	ergies
Shortness of Brea	ath					☐ Bee St	ting All	ergies
PREFERRED PHARM	ACY NAME:							
PHARMACY ADDRES	SS:							
PHARMACY PHONE	NUMBER:							
PATIENT SIGNATURE	<b>=:</b>					DATE:		
EMAIL:					PHON	NE:		

Patient Name:	
Date of Birth:	



# GOLDEN STATE ORTHOPEDICS & SPINE

### **HEALTH HISTORY, CONTINUED**

PATIENT NAME: _						
DATE OF BIRTH: _		DATE:				
EMAIL:			PHONE:	PHONE:		
WHAT BODY PART	S ARE INVOLVED?					
ON A SCALE OF 1	- <b>10</b> (10 BEING WORST) <b>, F</b>	HOW SEVERE IS YOUR	PAIN?			
□ 0 □ 1	<b>□</b> 2 <b>□</b> 3 <b>□</b> 4	□ 5 □ 6 □ 7	□8 □9 □10			
HOW WOULD YOU	DESCRIBE YOUR PAIN	l?				
Sharp Du	II ☐ Stabbing ☐	Throbbing Achir	g Burning Con	stant Intermittent		
☐ Wakes me from	sleep	Other:				
	· –					
DO YOU HAVE:						
	□ Nh.v.o.oo	Tin alia a	□ \M/a also a a a	Duvisia a		
	<del></del>		Weakness			
<del>_</del>						
			N? Yes No			
Location:		Dates:	/to	/		
HAVE YOU HAD AN	N MRI, CT OR X-RAYS F	OR THIS CONDITION?	☐ Yes ☐ No			
Which study?	☐ MRI ☐ CT	X-Rays				
Location:		Dates:	/to	/		