GOLDEN STATE ORTHOPEDICS & SPINE

HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR REVIEW BY YOUR PROVIDER.

Name: ______________________ Birth Date: ____/____/______ Age: ________

Height: ________ Weight: ________ Sex: ☐ M ☐ F Dominant Hand: ☐ Right ☐ Left

Referring Provider: ______________________ Occupation: ______________________

Email: ______________________ Phone: ______________________

PATIENT MEDICAL HISTORY *(mark all that apply)*

☐ 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	☐ DVT (Blood Clot)	☐ Kidney Disease	☐ Thyroid Disease	☐ Other: ________
☐ Cancer	☐ Fibromyalgia	☐ Lung Disease	☐ Heart Attack	________
Type & Year________	☐ Gout	☐ COPD	☐ Stroke	________
________	☐ Atrial Fibrillation	☐ Seizure Disorder	☐ Asthma	________

PREVIOUS SURGERIES & DATE(S): ☐ **NONE**

1.	2.
3.	4.
5.	6.

IS INJURY WORK RELATED? ☐ Yes ☐ No If yes, have you filed a work comp claim? ________

FAMILY MEDICAL HISTORY *(Mark if your immediate family members (mom, dad, siblings) have any of these conditions)*

☐ Alcoholism	☐ Bleeding	☐ Diabetes	☐ Heart Disease	☐ Kidney Disease	☐ Seizures
☐ Arthritis	☐ Cancer	☐ Gout	☐ High Blood Pressure	☐ Mental Illness	☐ Stroke

DO YOU EXERCISE REGULARLY? ☐ Yes ☐ No Describe: ______________________

TOBACCO USE: ☐ Yes ☐ No Describe: ______________________

ALCOHOL CONSUMPTION: ☐ Yes ☐ No If Yes: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Socially

RECREATIONAL/DRUG USE: ☐ Yes ☐ 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	Allergic Reaction

Patient Name: ______________________

Date of Birth: ______________________

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HEALTH HISTORY, CONTINUED

REVIEW OF SYMPTOMS *(Recent or current conditions only)*

Constitutional

- ☐ NONE
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Malaise
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss

Cardiovascular

- ☐ NONE
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Heart Palpitations
- ☐ Leg Swelling
- ☐ Fainting

Integumentary

- ☐ NONE
- ☐ Itchy Skin
- ☐ Rash
- ☐ Skin Infections
- ☐ Skin Lesions
- ☐ Contact Allergy

Metabolic/Endocrine

- ☐ NONE
- ☐ Hair Loss
- ☐ Heat Intolerant
- ☐ Cold Intolerant

Head, Eye, Ear, Nose & Throat

- ☐ NONE
- ☐ Vertigo
- ☐ Blurred/Double Vision
- ☐ Vision Loss
- ☐ Difficulty Swallowing
- ☐ Ear Drainage
- ☐ Facial Pain
- ☐ Headache
- ☐ Hearing Loss
- ☐ Nasal Congestion
- ☐ Ringing in Ears

Hematologic

- ☐ NONE
- ☐ Bleeding
- ☐ Bruising

Gastrointestinal

- ☐ NONE
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Frequent Constipation
- ☐ Heartburn
- ☐ Jaundice
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting

Neurological

- ☐ NONE
- ☐ Difficulty Walking
- ☐ Dizziness
- ☐ Poor Coordination
- ☐ Memory Loss
- ☐ Muscle Weakness
- ☐ Tremors
- ☐ Tingling

Psychiatric

- ☐ NONE
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Reproductive

- ☐ NONE
- ☐ Pregnant

Respiratory

- ☐ NONE
- ☐ Cough
- ☐ Dyspnea (Difficulty Breathing)
- ☐ Recent Infections
- ☐ Known TB Exposure
- ☐ Wheezing
- ☐ Shortness of Breath

Genitourinary

- ☐ NONE
- ☐ Dysuria (Painful Urination)
- ☐ Frequent Urination
- ☐ Hematuria (Blood in Urine)
- ☐ Urge Incontinence
- ☐ Urinary Incontinence

Immunological

- ☐ NONE
- ☐ Asthma
- ☐ Contact Dermatitis
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Seasonal Allergies
- ☐ Bee Sting Allergies

PREFERRED PHARMACY NAME: ______________________

PHARMACY ADDRESS: ______________________

PHARMACY PHONE NUMBER: ______________________

PATIENT SIGNATURE: ______________________ **DATE:** ____________

EMAIL: ______________________ **PHONE:** ____________

Patient Name: ______________________

Date of Birth: ______________________

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HEALTH HISTORY, CONTINUED

PATIENT NAME: ____

DATE OF BIRTH: ____________________ DATE: ____________________

EMAIL: ______________________________________ PHONE: ____________________

WHAT BODY PARTS ARE INVOLVED?

____

____

____

ON A SCALE OF 1 - 10 *(10 BEING WORST)*, **HOW SEVERE IS YOUR PAIN?**

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

HOW WOULD YOU DESCRIBE YOUR PAIN?

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Constant ☐ Intermittent

☐ Wakes me from sleep ☐ Other: ______________________________

____

____

DO YOU HAVE:

☐ Swelling ☐ Numbness ☐ Tingling ☐ Weakness ☐ Bruising

☐ Other: ____

HAVE YOU HAD ANY PHYSICAL THERAPY FOR THIS CONDITION? ☐ Yes ☐ No

Location: ______________________ Dates: ____/____/______ to ____/____/______

HAVE YOU HAD AN MRI, CT OR X-RAYS FOR THIS CONDITION? ☐ Yes ☐ No

Which study? ☐ MRI ☐ CT ☐ X-Rays

Location: ______________________ Dates: ____/____/______ to ____/____/______