beach cities orthopedics & sports medicine

NEW PATIENT MEDICAL HISTORY

MEDICAL HISTORY: Please check if **you** have any of the following:

High blood pressure ☐	Diabetes ☐	Stroke ☐
Heart disease ☐	Cancer ☐	Respiratory Problems/Asthma ☐
Bleeding problems ☐		

OTHER MEDICAL PROBLEMS (Please List)

_____

_____

_____

Past hospitalizations/surgeries/injuries and approximate dates.

_____

_____

_____

_____

_____

Allergies (Medication or Latex) (Please List)

_____

_____

Current Medications:

1._____ 2. _____

3.._____ 4. _____

5._____ 6. _____

7._____ 8. _____

9._____ 10. _____

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NEW PATIENT MEDICAL HISTORY

FAMILY HISTORY:

Please check if any of your relatives ever had any of the following problems- indicate who:

Heart disease	☐ Who:_____	High blood pressure	☐ Who:_____
Diabetes	☐ Who:_____	Stroke	☐ Who:_____
Cancer	☐ Who:_____	Thyroid disease	☐ Who:_____

SOCIAL HISTORY:

Marital status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Tobacco use: ☐ never ☐ quit-when_____ ☐ smoker/pack per day_____

Alcohol use: ☐ never ☐ rarely ☐ moderate ☐ daily

Drug use: ☐ never ☐ type and frequency_____

REVIEW OF SYSTEMS (Check all that apply to you)

Constitutional
- ☐ Good General Health
- ☐ Recent weight change
- ☐ Night sweats, fevers
- ☐ Fatigue

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Heart trouble
- ☐ Swelling hands/feet

Musculoskeletal
- ☐ Muscle pain or cramps
- ☐ Stiffness/swelling in joints
- ☐ Joint pain
- ☐ Trouble walking

Endocrine
- ☐ Excessive thirst/urination
- ☐ Thyroid disease
- ☐ Hormone problem

Genitourinary – Male only
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sexual problems
- ☐ Testicle pain

Ears/Nose/Mouth/Throat
- ☐ Hearing loss or ringing
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat/voice change

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing/asthma
- ☐ Coughing up blood

Neurological
- ☐ Frequent headaches
- ☐ Paralysis or tremors
- ☐ Convulsions/seizures
- ☐ Numbness/tingling

Hematologic/Lymphatic
- ☐ Bruise easily
- ☐ Slow to heal
- ☐ Enlarged glands

Genitourinary-Female only
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sexual problems
- ☐ Menstrual pain

Eyes
- ☐ Wear glasses/contacts
- ☐ Blurred/double vision
- ☐ Eye disease or injury
- ☐ Glaucoma

Gastrointestinal
- ☐ Nausea/vomiting
- ☐ Abdominal Pain
- ☐ Rectal Bleeding
- ☐ Bowel problems

Integumentary (Skin/Breast)
- ☐ Change in hair/nails
- ☐ Rashes or itching
- ☐ Breast lump
- ☐ Breast pain or discharge

Allergic/Immunologic
- ☐ Food allergies
- ☐ Aspirin allergies
- ☐ Antibiotic allergies

Psychiatric
- ☐ Insomnia
- ☐ Confusion/memory loss
- ☐ Depression
- ☐

Patient Statement: To the best of my knowledge, the above information is accurate.

Signed:_____Date:_____