CHRISTUS SANTA ROSA MEDICAL GROUP
Westover Hills Orthopaedics

OUR MISSION "To Extend the Healing Ministry of Jesus Christ"

Jeffrey A. Dean, M.D.
Board Certified, Sports Medicine
& Orthopaedic Surgery
Brian N. Kanz, M.D
Orthopaedic Surgery

Medical Plaza II
1212 State Highway 151, Suite 250
San Antonio, Texas 7825
Tel 210.703.9758 – Fax 210.703.9759

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: ______________________________ **DOB:** ______________

Visit related to Worker's Comp? Y / N **Date of Injury:** __________ **Today's Date:** __________

Visit related to Vehicle Accident? Y / N **Date of Accident:** __________

Reason for Initial Visit: ____
____
____

Medications: (Prescription, non-prescription, vitamins, supplements, etc)

MEDICATION	**DOSAGE**	**Times/Day**	**MEDICATION**	**DOSAGE**	**Times/Day**

Allergies/Reactions to foods/medications/other agents:

Medication/Food/Other Agent	**Reaction or side effect**

Personal Medical History:

Heart Disease	Y / N	Comment:
Myocardial Infarction/Heart Attack	Y / N	
Hypertension / High Blood Pressure	Y / N	
Diabetes Mellitus	Y / N	
High Cholesterol	Y / N	
Stroke	Y / N	
Thyroid Problem	Y / N	
Bleeding/Clotting Problems	Y / N	
Cancer	Y / N	Type:
Asthma	Y / N	
Kidney Disease	Y / N	
Have you ever had a blood transfusion?	Y / N	Transfusion Date:
Osteoarthritis	Y / N	
Rheumatoid Arthritis	Y / N	
Osteoporosis	Y / N	
Sleep Apnea	Y / N	
Other:	**Y / N**	**Comment:**

Surgical History:

Surgery	**Date**	**Surgery**	**Date**

Patient Name: ______________________________ **DOB:** ______________

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Review of Systems:

Symptoms		**If Yes, explain:**
Fever/Chills/Sweats	Y / N	
Unexplained weight loss / gain	Y / N	
Fatigue/Weakness	Y / N	
Excessive thirst/urination	Y / N	
Change in vision	Y / N	
Difficulty hearing	Y / N	
Problems with teeth/gums	Y / N	
Hay fever/allergies	Y / N	
Chest pain/discomfort	Y / N	
Leg pain with exercise	Y / N	
Palpitations	Y / N	
Cough/wheezing	Y / N	
Difficulty breathing	Y / N	
Abdominal pain	Y / N	
Blood in bowel movement	Y / N	
Nausea/vomiting/diarrhea	Y / N	
Difficulties with urination	Y / N	
Nighttime urination	Y / N	
Muscle/joint pain	Y / N	
Joint swelling/redness	Y / N	
Skin rashes	Y / N	
Headaches	Y / N	
Dizziness/loss of coordination	Y / N	
Numbness	Y / N	
Memory loss	Y / N	
Anxiety/stress	Y / N	
Depression	Y / N	
Easy bruising or bleeding	Y / N	
Other:		

Social History:

Tobacco Use Y / N Type: ___________ Yrs smoked: ___________ Yr Quit: _______________

Alcohol Use Y / N Type: __________ Drinks/wk: ____________

Drug Use Y / N Recreational: Y / N Ever used needles? Y / N

Family History:

Disease	**Parent**	**Sibling**	**Child**	**Other**
Arthritis				
Osteoporosis				
Cancer: (Type)				
Diabetes				
Heart Disease				
High Blood Pressure				
Other				

Review Date: ___________________ MD Initials: _______________ Patient Initials: _________________

___________________ _______________ _________________

___________________ _______________ _________________