

Santa Cruz Orthopaedic Institute

Patient Medical History

Name: _____ Date of Visit: _____
 Primary Care Physician: _____ Date of Injury: _____
 Other Physicians: _____ Date of Birth: _____

Reason for Today's Visit/Chief Complaint (side specific R/L): _____

Describe the Injury in Detail, Including Date: _____

Is This Injury Work Related: Yes No **Result of An Auto Accident:** Yes No

Past Medical History:	Yes	No	Detail Below
Ear, Nose, Throat Problem	_____	_____	_____
Coronary Artery Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Lung Disease	_____	_____	_____
Kidney/Liver Disease	_____	_____	_____
Stomach/Intestinal Disease	_____	_____	_____
Arthritis	_____	_____	_____
Diabetes	_____	_____	_____
Epilepsy	_____	_____	_____
Infections (including TB)	_____	_____	_____
Cancer	_____	_____	_____
Vascular Disease	_____	_____	_____
Psychiatric Problems	_____	_____	_____
DVT	_____	_____	_____
Blood Clots	_____	_____	_____
RSD	_____	_____	_____
CRPS	_____	_____	_____
Fibromyalgia	_____	_____	_____
Chronic Pain	_____	_____	_____
Anesthesia Complications	_____	_____	_____

Family History of Any of the Above Diseases: _____

Past Surgical History: _____

Social History:
 Alcohol Use Yes No Amount/duration: _____
 Drug Use Yes No Amount/duration: _____
 Tobacco Use Yes No Amount/duration: _____
 Recreational Activities (hobbies/sports): _____

Name: _____

Date: _____

Symptom Review	Yes	No	Duration/Frequency
Headache/dizziness/visual changes	_____	_____	_____
Throat Problems/Runny Nose	_____	_____	_____
Chest Pain/Palpitation/Irregular heartbeat	_____	_____	_____
Shortness of Breath/Cough	_____	_____	_____
Leg Swelling	_____	_____	_____
Heartburn/Nausea/vomiting/diarrhea	_____	_____	_____
Burning/frequent urination	_____	_____	_____
Muscle/Bone/Joint pain or stiffness	_____	_____	_____
Discoloration/temperature changes of Extremity	_____	_____	_____
Loss of Sensation	_____	_____	_____
Numbness or Tingling in Extremity	_____	_____	_____
Night pain or pain at rest in extremity	_____	_____	_____
Low Back pain	_____	_____	_____
Fever/chills/sweats/fatigue	_____	_____	_____
Easy Bruising or Bleeding disorder	_____	_____	_____
Weight gain or loss	_____	_____	_____
Excessive Thirst or hunger	_____	_____	_____
Excessive worry/anxiety/depression	_____	_____	_____
Trouble Sleeping	_____	_____	_____
Dietary Restriction	_____	_____	_____

Walking Distance: Blocks 1 2 3 4 5 Miles _____

Use of Walking Assistance Device: Cane Walker Crutches

Type of Shoes Most Frequently Worn: Running Shoes Loafers Oxfords Sandals

Is there any legal action currently pending in this injury? _____

If Work Related Injury Information

Date of Injury: _____

Extremity currently listed in your current claim: _____

Work Title with Brief Job Description: _____

Currently Working: Yes No

Current Work Restrictions: _____

Last Day Worked: _____

Lawyer involved in case: Yes No

Name of Attorney _____ Telephone# _____

Pain and Function Score

My Pain is: (please circle a number)

None _____ Severe
 0 1 2 3 4 5 6 7 8 9 10

My Function is: (please circle a number)

Normal _____ Severely Limited
 0 1 2 3 4 5 6 7 8 9 10

