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:_____