beach cities orthopedics
& sports medicine

NEW PATIENT MEDICAL HISTORY (MINOR)

Patient Height _____ feet _____ inches Patient Weight: _____ lbs

Hand Dominance (circle one) Right Left Both

Activites (i.e. running, surfing, swimming, basketball, golf, etc.) _____

_____

_____

Medical History Please check if you have any of the following:

□ High blood pressure □ Diabetes □ Stroke

□ Heart disease □ Cancer □ Respiratory problems

□ Bleeding problems □ HIV □ Hepatitis □ A □ B □ C

Other Medical Problems (please specify) _____

_____

_____

Past hospitalizations, surgeries, and injuries with approximate dates _____

_____

_____

_____

_____

Allergies (Medication or latex) _____

_____

_____

Current Medications _____

_____

_____

_____

Immunizations

□ Current & up-to-date □ Not given

If all immunizations not given, has patient received Tetanus/booster? □ Yes □ No Date last given _____

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

Home status Lives with □ both parents □ mother □ father □ other _____

Siblings brothers _____ sisters _____ pets _____

Does the patient have any developmental delays? □ Yes □ No

If yes, please explain: _____

_____

Tobacco use □ never □ quit when _____ □ smoker packs per day _____

Alcohol use □ never □ rarely □ moderate □ daily

Drug use □ never □ type & frequency _____

Review of Systems (check all that apply to you)

Constitutional
□ Good general health
□ Recent weight change
□ Night sweats, fevers
□ Fatigue

Cardiovascular
□ Chest pains
□ 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)
□ Changes 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

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

Parent/guardian signature _____ Date _____

Physician statement: I have reviewed the questionnaire with the patient.

Physician signature _____ Date _____