



MISSION PEAK ORTHOPAEDIC MEDICAL GROUP, INC.

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Medical History and Information : Pharmacy name and phone #

What name do you prefer to be called Height Weight Left or Right Handed: L / R

Medical reason for today's visit Has this condition caused you to miss work? NO/ IF YES Dates

Do you have allergies to any medications? NO / If Yes, Penicillin Sulfa Novocain Codeine Other
What Happens

Do you have allergies to foods/other(tape,dye)? NO/ If Yes please describe

Please answer the following questions carefully—Have you had:

- Yes No
Diabetes
Hypoglycemia-low blood sugar
Heart Problems (Rheumatic fever, murmur, chest pain, heart attack, irregular heartbeat, ankle swelling, valve surgery)
High Blood Pressure
Stroke (weakness of numbness on one side, difficulty speaking, loss of vision)
Seizures (epilepsy, convulsions, blackouts)
Severe Headaches
Lung problems (asthma, chronic cough, pneumonia, wheezing, shortness of breath, emphysema, cancer)
Tuberculosis/TB
Sleep Apnea
Liver Problems (jaundice, hepatitis)
Kidney, Bladder or Prostate Problems (infection, kidney stones, urinary frequency or urgency)
Stomach Problems(ulcer, hiatal hernia, heartburn, reflux)
Bowel Problems (irritable bowel, diverticulosis, diarrhea, ulcerative colitis, Chron's disease)
Fever/Chills
Night Sweats

- Yes No
Fatigue
Cancer
Blood Clots, Transfusion Problems, Bleeding
Tendency(deep vein thrombosis, pulmonary embolus, phlebitis, hemophilia)
Thyroid Problems
Back Problems (strain, disc protrusion or herniation)
Broken bones of head, Neck or Spine of restrictions in movement
Arthritis (osteoarthritis, rheumatoid, psoriatic)
Autoimmune Disorders (lupus, rheumatoid arthritis, Reynauds)
Mental Health Disorders/Phobias
Muscle disorders (MD, myasthenia gravis)
Skin Disorders
Neurological Problems (numbness in hands or feet, muscle weakness, inability to hold onto objects, dizziness)
Other Medical Disorders
(Please list)

Yes No Please answer the following questions if they apply to you

- Have had a illness, cold, cough or fever within the last week
Recent exposure to communicable diseases
Is there a possibility you are pregnant? Last menstrual period
Do you have a history of smoking? Packs/day #of years Date Quit
Do you drink alcoholic beverages? How often How much
Do you have a history of substance abuse or addiction?
Have taken oral or injectable steroids?
Do you need help around the house, to do errands, take care of personal needs?
Do you live alone?
Have you have recent unexplained weight loss?
Do you have a loss of appetite?
Are you involved in litigation for this injury?

If the patient is a child:

- Please answer the following questions
Yes No
Child was premature
Birth defects or developmental problems
Immunization problems or delays
History of frequent fractures

Prior Treatment for today's problem :

- Physical Therapy Last Visit / /
Injection site Date / /
Medicines List
Surgery

Any health conditions of Immediate Family Members (Please describe)

Previous Surgery Hospitalizations Or Operations :NONE / IF YES please list

Current Medications:(list Name & Dosage) NONE/IF YES please list

Please use reverse side if more room needed

Patient (or Guardian) Signature Date / /