



GOLDEN STATE ORTHOPEDICS & SPINE

HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR REVIEW BY YOUR PROVIDER.

Name: _____ Birth Date: ____/____/____ Age: _____

Height: _____ Weight: _____ Sex: M F Dominant Hand: Right Left

Referring Provider: _____ Occupation: _____

Email: _____ Phone: _____

PATIENT MEDICAL HISTORY (mark all that apply)

- Acid Reflux Depression Hepatitis Osteoporosis Anemia
- AIDS/HIV Diabetes High Blood Pressure Sleep Apnea Enlarged Prostate
- Arthritis Drug Abuse Irregular Heart Beat Liver Disease Heart Disease
- Bleeding Disorder DVT (Blood Clot) Kidney Disease Thyroid Disease Other: _____
- Cancer Fibromyalgia Lung Disease Heart Attack _____
- Type & Year _____ Gout COPD Stroke _____
- _____ Atrial Fibrillation Seizure Disorder Asthma _____

PREVIOUS SURGERIES & DATE(S): NONE

1.	2.
3.	4.
5.	6.

IS INJURY WORK RELATED? Yes No If yes, have you filed a work comp claim? _____

FAMILY MEDICAL HISTORY (Mark if your immediate family members (mom, dad, siblings) have any of these conditions)

- Alcoholism Bleeding Diabetes Heart Disease Kidney Disease Seizures
- Arthritis Cancer Gout High Blood Pressure Mental Illness Stroke

DO YOU EXERCISE REGULARLY? Yes No Describe: _____

TOBACCO USE: Yes No Describe: _____

ALCOHOL CONSUMPTION: Yes No If Yes: Daily Weekly Occasionally Socially

RECREATIONAL/DRUG USE: Yes No Type/Amount/Frequency: _____

ALLERGIES: (If yes, please list) Yes No

Latex Allergy/Sensitivity Yes No

Metal Allergy Yes No

Shellfish Allergy Yes No

Medication/Food	Allergic Reaction



Patient Name: _____

Date of Birth: _____

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HEALTH HISTORY, CONTINUED

REVIEW OF SYMPTOMS *(Recent or current conditions only)*

Constitutional

- NONE
- Fever
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss
- Chills
- Fatigue
- Malaise

Cardiovascular

- NONE
- Heart Murmur
- Irregular Heart Beat
- Heart Palpitations
- Leg Swelling
- Fainting
- Chest Pain

Integumentary

- NONE
- Itchy Skin
- Rash
- Skin Infections
- Skin Lesions
- Contact Allergy

Metabolic/Endocrine

- NONE
- Hair Loss
- Heat Intolerant
- Cold Intolerant

Head, Eye, Ear, Nose & Throat

- NONE
- Blurred/Double Vision
- Difficulty Swallowing
- Ear Drainage
- Facial Pain
- Headache
- Hearing Loss
- Nasal Congestion
- Ringing in Ears
- Vertigo
- Vision Loss

Hematologic

- NONE
- Bleeding
- Bruising

Gastrointestinal

- NONE
- Abdominal Pain
- Constipation
- Frequent Constipation
- Heartburn
- Jaundice
- Loss of Appetite
- Nausea
- Vomiting

Neurological

- NONE
- Difficulty Walking
- Dizziness
- Poor Coordination
- Memory Loss
- Muscle Weakness
- Tremors
- Tingling

Psychiatric

- NONE
- Anxiety
- Depression
- Insomnia

Respiratory

- NONE
- Cough
- Dyspnea (Difficulty Breathing)
- Recent Infections
- Known TB Exposure
- Wheezing
- Shortness of Breath

Genitourinary

- NONE
- Dysuria (Painful Urination)
- Frequent Urination
- Hematuria (Blood in Urine)
- Urge Incontinence
- Urinary Incontinence

Immunological

- NONE
- Asthma
- Contact Dermatitis
- Environmental Allergies
- Food Allergies
- Seasonal Allergies
- Bee Sting Allergies

PREFERRED PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE NUMBER: _____

PATIENT SIGNATURE: _____ DATE: _____

EMAIL: _____ PHONE: _____



Patient Name: _____

Date of Birth: _____

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HEALTH HISTORY, CONTINUED

PATIENT NAME: _____

DATE OF BIRTH: _____ DATE: _____

EMAIL: _____ PHONE: _____

WHAT BODY PARTS ARE INVOLVED?

ON A SCALE OF 1 - 10 (10 BEING WORST), HOW SEVERE IS YOUR PAIN?

0 1 2 3 4 5 6 7 8 9 10

HOW WOULD YOU DESCRIBE YOUR PAIN?

Sharp Dull Stabbing Throbbing Aching Burning Constant Intermittent
 Wakes me from sleep Other: _____

DO YOU HAVE:

Swelling Numbness Tingling Weakness Bruising
 Other: _____

HAVE YOU HAD ANY PHYSICAL THERAPY FOR THIS CONDITION? Yes No

Location: _____ Dates: ____/____/____ to ____/____/____

HAVE YOU HAD AN MRI, CT OR X-RAYS FOR THIS CONDITION? Yes No

Which study? MRI CT X-Rays

Location: _____ Dates: ____/____/____ to ____/____/____