

FAIR OAKS ORTHOPAEDIC ASSOCIATES, INC. – MEDICAL HISTORY

Name: _____ **Today's Date:** _____
(Last Name) (First Name) (Middle Name)

Chief Complaint: _____ **Affected Area** Rt / Lt _____ **Date Onset** ___/___/___
mon day yr

Injury Related No / Yes **Date** _____ **Right handed/Left handed (circle one)**
Auto Accident No / Yes **Date** _____ **Insurance Carrier** _____
Work Related Injury No / Yes **Date** _____ **Compensation Carrier** _____

Alcohol Use: No Yes **Amt.** _____ **Tobacco use:** No Yes **Packs per day** _____

Please Describe Reason For Visit:

Past Medical History

Review Of Systems (Recent Problems)
Circle All That Apply

- Diabetes No Yes
- Cancer (type): No Yes
- Ulcers No Yes
- Depression/Nervousness No Yes
- Blood Pressure No Yes
- Lung Disease No Yes
- Heart Problems No Yes
- Infections No Yes
- Past Blood Transfusion No Yes
- Arthritis No Yes
- Liver Disease/Hepatitis No Yes
- Kidney Disease No Yes
- Bleeding Problems No Yes
- Blood Clots No Yes

- GENERAL** Weight loss/ Fever / chills None
- SKIN** Rashes / Sores / Swollen Nodes None
- HEART** Chest pain /Palpitations / Irregular beats None
- LUNGS** Short of breath / Coughs / Bronchitis None
- G.I.** Gastritis / Nausea / Vomiting / Pain None
- G.U** Painful Urination/ Leaking/ Burning None
- MUSCLE** Joint Pain/Swelling/Stiffness/weakness None
- NEURO** Numbness/ Tingling/Unsteadiness None
- PSYCH** Anxiety / depression/ addiction None
- BLOOD** Anemia / Abnormal Bleeding None
- ENT** Sinusitis / Hoarseness / Swallowing Prob. None
- EYES** Change in Vision / Sensitivity to Light None

Other: _____

Allergies/Reactions: _____

Family History: Do any of your blood relatives have or have had any of these diseases:

- Diabetes No Yes **Type** _____ **TB** No Yes
- Cancer No Yes **Site** _____ **Thyroid Disease** No Yes
- Heart problem No Yes **Type** _____ **High Blood Pressure** No Yes
- Stroke No Yes
- Others: _____

List Past Surgeries: _____

List Current Medicines: _____

