



**BRANDON ORTHOPEDIC ASSOCIATES
EAST BAY SPORTS MEDICINE & ORTHOPEDICS**

Board Certified Orthopedic Surgery
Sports Medicine

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Please answer ALL questions on all four pages. Check boxes or fill in blanks where indicated. These responses will aid your doctor in caring for you.

1. **NAME:** _____ **DATE:** _____

HEIGHT: _____ **WEIGHT:** _____ **AGE:** _____

LEFT HANDED or **RIGHT HANDED?**

2. **DESCRIBE YOUR PROBLEM TODAY:** _____

_____ Right or left side? _____

When did this problem start? (Date or length of time?) _____

Have you ever had a similar injury or problem in this area?

Yes No

When? _____

Have you ever been treated by a doctor for today's problem?

Yes No

Doctor's name/location: _____

3. **Have you or a family member seen one of our doctors before?** No Yes
If so, which one? _____

4. **Is this a Worker's Compensation injury?** Yes No

Have you ever been hurt on the job before? Yes No

Type of previous work injury? _____

5. **How were you referred to our office:** (please fill in)

Doctor _____ Clinic _____ Hospital _____

Friend _____ Attorney _____ Previous patient _____

Other _____

6. **Do you have an attorney representing you for this problem?** Yes No
Attorney's name/address: _____

7. **FOR WOMEN ONLY:** Could you be pregnant? No Yes
Date of your last menstrual cycle? _____

8. **SOCIAL HISTORY:**

Marital Status: Single Married Divorced Widowed Partner

Tobacco Use: Never Quit: If so, When? _____

Current smoker: packs per day _____

Chew: Frequency _____

Alcohol Use: Never Rarely Moderate Daily "Social"
How much? _____

Recreational Drugs Use: Never Type & Frequency _____

Occupation:

If retired, previous occupation: _____

9. **FAMILY HISTORY:** Please list any medical problems in your relatives.
Father: _____ Mother: _____
Siblings: _____ Other: _____

PATIENT STATEMENT:

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

Signature of Patient/Responsible Party

Date

Relationship

(Please Complete Next 2 Pages)

REVIEW OF SYSTEMS: Please check (Y) or (N) for each of the following:**Constitutional**

Good General Health Y N
 Recent Weight Change Y N
 Night Sweats/Fevers Y N
 Fatigue Y N

Eyes

Wear glasses/contacts Y N
 Blurred/double vision Y N
 Eye disease or injury Y N
 Glaucoma Y N

Respiratory

Shortness of Breath Y N
 Cough Y N
 Wheezing/Asthma Y N
 Coughing up blood Y N

Musculoskeletal

Muscle pain/cramps Y N
 Stiff/swelling joints Y N
 Joint Pain Y N
 Trouble walking Y N

Integumentary(Skin/Breast)

Change in hair/nails Y N
 Rashes or Itching Y N
 Breast lump Y N
 Breast pain/discharge Y N

Hematologic/Lymphatic

Bruise easily Y N
 Slow to heal Y N
 Enlarged glands Y N

Genitourinary-Male

Blood in urine Y N
 Kidney stones Y N
 Sexual Problems Y N
 Testicle Pain Y N

Psychiatric

Insomnia Y N
 Confusion/memory loss Y N
 Depression Y N

Ears/Nose/Mouth/Throat

Hearing loss/ringing in ears Y N
 Sinus Problems Y N
 Nose Bleeds Y N
 Sore Throat Y N

Cardiovascular

Chest Pain Y N
 Palpitations Y N
 Heart Trouble Y N
 Pacemaker Y N
 Defibrillator Y N
 Swelling of hands/feet Y N
 Heart Attack/Heart Failure Y N
 Stent Y N

Gastrointestinal

Nausea/Vomiting Y N
 Abdominal Pain Y N
 Rectal Bleeding Y N
 Bowel Problems Y N

Neurological

Frequent headaches Y N
 Migraines Y N
 Stroke Y N
 TIA (mini-stroke) Y N
 Paralysis Y N
 Convulsions/seizures Y N
 Numbness/tingling Y N

Endocrine

Excessive thirst Y N
 Thyroid disease Y N
 Hormone Problem Y N
 Diabetes Y N
 Insulin Use Y N

Allergic/Immunologic

Food Allergies Y N
 Aspirin Allergies Y N
 Antibiotic Allergies Y N

Genitourinary-Female

Blood in urine Y N
 Kidney stones Y N
 Sexual Problems Y N
 Menstrual Problems Y N

MEDICAL HISTORY: Please check (Y) or (N) to indicate if you have or have had any of the following medical problems.

No Significant Past Medical History

- | | | | | | |
|---------------------|----------------------------|----------------------------|----------------------|----------------------------|----------------------------|
| High Blood Pressure | <input type="checkbox"/> Y | <input type="checkbox"/> N | Diabetes | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Heart Trouble | <input type="checkbox"/> Y | <input type="checkbox"/> N | Respiratory Problems | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Stroke | <input type="checkbox"/> Y | <input type="checkbox"/> N | Cancer | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Bleeding Problems | <input type="checkbox"/> Y | <input type="checkbox"/> N | HIV/AIDS | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Hepatitis | <input type="checkbox"/> Y | <input type="checkbox"/> N | Intestinal Problems | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| Ulcer | <input type="checkbox"/> Y | <input type="checkbox"/> N | | | |

Other: _____

Current Medications: (attach list if needed)

None _____

Past Hospitalizations: (Surgeries, Injuries or Medical Conditions and Approximate Dates)

None

Date:	Reason:
_____	_____
_____	_____
_____	_____
_____	_____

List ALL ALLERGIES to medications:

None _____

List ALL other ALLERGIES:

None _____

PATIENT STATEMENT:

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

Signature of Patient/Responsible Party

Date

Relationship