Los Angeles Orthopaedic Center

NAME:_____ AGE:_____ DATE OF VISIT:_____
CHIEF COMPLAINT:_____ DATE OF INJURY:_____
WHO REFERRED YOU TO US:_____HEIGHT:_____WEIGHT:_____
HISTORY OF PRESENT INJURY (What caused your current condition or injury?): _____
_____
_____
_____
PREVIOUS TREATMENT (What kind of treatment have you had?, (i.e. Medication, P.T., MRI)): _____
_____
PAST MEDICAL HISTORY: Circle any of the following which you have had or have at present:

Heart Failure	Emphysema/Bronchitis	Artificial Joint Replacement
Heart Disease or Attack	Cough	Stomach Problems, Ulcer, Gastritis
High Blood Pressure	Tuberculosis (TB)	Kidney or Bladder Trouble
Heart Murmur	Asthma	AIDS or HIV
Artificial Heart Valve	Diabetes	Blood Transfusion
Heart Pacemaker	Thyroid Disease	Hemophilia or Bleeding Problems
Heart Surgery	Rheumatoid	Sickle Cell Disease
CVA or Stroke	Lupus	Hepatitis
Cancer	Gout	Liver Disease
Chemotherapy	Pseudo-gout	Epilepsy or Seizures
Radiation	Arthritis	Depression or Anxiety
Blood Clots or Phlebitis	Osteoporosis	Drug Addiction

OTHER MEDICAL PROBLEMS:_____ ARE YOU PREGNANT?:_____
PAST SURGICAL HISTORY: _____
_____
CURRENT MEDICATIONS: _____
_____
ALLERGIES: _____
SOCIAL HISTORY: Do you smoke? Y N, How much:_____ Occupation:_____
Do you drink alcohol? Y N, How much:_____ Dominant Hand: R L
Do you do drugs? Y N, What kind:_____

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

_____ _____
Date *Signature of Patient, Parent, or Guardian*

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=PHYSICAL
EXAM:_____
_____
_____
_____
RADIOGRAPHIC FINDINGS:
_____
_____
TREATMENT PLAN: _____
_____
MEDICATION SAMPLES:_____ EDUCATION / INSTRUCTION: _____