



Riverside Orthopaedic
and Sports Medicine

ASSOCIATES

Medical History Questionnaire

Name: _____ Date _____ Age _____ M F
R L hand dominant Date of Injury _____ Height _____ Weight _____

Chief Complaint: please describe, in detail, your current injury or complaint (which limb, initial symptoms, aggravating activities)

PRESENT MEDICATION: please list all the medications and supplements you are taking or have taken in the last month

ALLERGIES: please list allergies to food or medication

PAST SURGERIES/ILLNESSES/ACCIDENTS AND HOSPITALIZATIONS

FAMILY HISTORY:

FATHER: Age _____ Living/Deceased Cancer Diabetes Heart Disease Stroke other _____
MOTHER: Age _____ Living/Deceased Cancer Diabetes Heart Disease Stroke other _____

REVIEW OF SYSTEMS:

HEAD AND NECK		YES NO	YES NO	YES NO	
Severe headaches	<input type="checkbox"/> <input type="checkbox"/>	Double Vision	<input type="checkbox"/> <input type="checkbox"/>	Swelling in neck	<input type="checkbox"/> <input type="checkbox"/>
Dizzy Spells	<input type="checkbox"/> <input type="checkbox"/>	Difficulty hearing	<input type="checkbox"/> <input type="checkbox"/>	Fainting	<input type="checkbox"/> <input type="checkbox"/>
Failing Vision	<input type="checkbox"/> <input type="checkbox"/>	Prolonged hoarseness	<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>
HEART AND LUNGS		YES NO	YES NO	YES NO	
Chest Pain	<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Pneumonia	<input type="checkbox"/> <input type="checkbox"/>
Heart Attack	<input type="checkbox"/> <input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/>	Heart defects / murmurs	<input type="checkbox"/> <input type="checkbox"/>
Skipping Heart Beats	<input type="checkbox"/> <input type="checkbox"/>	Chronic Coughing / TB	<input type="checkbox"/> <input type="checkbox"/>	Ankles Swell.	<input type="checkbox"/> <input type="checkbox"/>
STOMACH AND INTESTINES		YES NO	YES NO	YES NO	
Persistent nausea	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/> <input type="checkbox"/>
Heartburn regularly	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis / jaundice	<input type="checkbox"/> <input type="checkbox"/>	Black or blood in stool	<input type="checkbox"/> <input type="checkbox"/>
Appetite loss	<input type="checkbox"/> <input type="checkbox"/>	Chronic diarrhea / constipation	<input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>
URINARY TRACT – etc		YES NO	YES NO	YES NO	
Excess urination	<input type="checkbox"/> <input type="checkbox"/>	Urinary problems	<input type="checkbox"/> <input type="checkbox"/>	Painful / excess menstruation	<input type="checkbox"/> <input type="checkbox"/>
Difficult urination	<input type="checkbox"/> <input type="checkbox"/>	Passed any stones	<input type="checkbox"/> <input type="checkbox"/>	Bleed between periods	<input type="checkbox"/> <input type="checkbox"/>
Blood in urine	<input type="checkbox"/> <input type="checkbox"/>	Retention of urine	<input type="checkbox"/> <input type="checkbox"/>	Pregnancies # _____	<input type="checkbox"/> <input type="checkbox"/>
MUSCLES JOINTS NERVES		YES NO	YES NO	YES NO	
Tingling sensations	<input type="checkbox"/> <input type="checkbox"/>	Memory loss	<input type="checkbox"/> <input type="checkbox"/>	Seizures	<input type="checkbox"/> <input type="checkbox"/>
Numbness	<input type="checkbox"/> <input type="checkbox"/>	Personality Changes	<input type="checkbox"/> <input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/>
Disturbance in walking	<input type="checkbox"/> <input type="checkbox"/>	Paralysis	<input type="checkbox"/> <input type="checkbox"/>	Varicose veins	<input type="checkbox"/> <input type="checkbox"/>
Muscle Jerking	<input type="checkbox"/> <input type="checkbox"/>	Speech disturbance	<input type="checkbox"/> <input type="checkbox"/>		
OTHER		YES NO	YES NO	<input type="checkbox"/> ALL OTHERS NEGATIVE	
Skin Disorders	<input type="checkbox"/> <input type="checkbox"/>	Bleeding disorders	<input type="checkbox"/> <input type="checkbox"/>		
EBV, CMV, HIV (circle)	<input type="checkbox"/> <input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/> <input type="checkbox"/>		

Occupation / position _____
Do you smoke or have you been a smoker? _____ packs per day X _____ years
Do you drink alcohol? How much? _____ Non-prescription drug use _____