ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

NEW PATIENT HISTORY

Name: _____ **DOB:** _____ **Date:** _____

Height: _____ **Weight:** _____ **Age:** _____ **Dominant Hand:** _____

Name of Referring Physician: _____

CHIEF COMPLAINT: *What orthopaedic problem brings you here today?*

Extremity: _____ ☐ Right ☐ Left ☐ Both

HISTORY OF PRESENT INJURY OR CONDITION:

How and when did it happen?

What makes it better?

What makes it worse?

Any previous treatment?

SURGERIES: List any previous surgeries including what type and dates:

PAST MEDICAL HISTORY – ILLNESSES: List all medical problems (such as diabetes, rheumatoid arthritis, high blood pressure, heart disease, infections, etc.)

MEDICATIONS: List all medications you take routinely including their strength and how many times a day?

Name of Medication	Strength/Dose	How often do you take it?

ALLERGIES: List all medications, foods, prep solutions or materials.

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FAMILY HISTORY: Any medical problems in your family: mother, father, siblings, etc.?

_____

SOCIAL HISTORY: What kind of work do you do?

What are your interests/hobbies? Do you participate in any recreational activities?

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

Any other information you would like doctor to know about you or your condition?

Review of Systems

(Check all that apply)

Constitutional:	Weight Loss _____	Weight Gain _____	Fatigue_____
Skin:	Rashes _____	Sores _____	
Eyes:	Visual Difficulty ____	Eye Irritation _____	
Ears, Nose, Throat:	Sore Throat _____	Difficulty Swallowing __	Ear Ache _____
Gastrointestinal:	Abdominal Pain ____	Nausea _____	Vomiting _____ Jaundice _____
Genitourinary:	Painful Urination ___	Bloody Urine _____	Urination at Night _____
Respiratory:	Chronic Cough _____	Shortness of Breath ____	
Cardiovascular:	Chest Pain _____	Palpitations _____	
Musculoskeletal:	Joint Pain _____	Swollen Joints _____	Sore Muscles _____
Neurologic:	Numbness _____	Weakness _____	
Hematologic:	Anemia _____	Bleeding Tendencies ___	

Initial and date here if none of the above apply: _____

Primary Care Physician:_____	**Phone:**_____
Address:_____	**City:**_____
Pharmacy:_____	**Phone:**_____
Address:_____	**City:**_____

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Accident/Injury Information Form

Name: _____ Doctor: _____

To help us process your insurance claim quickly and efficiently please provide us with your accident/injury details:

When did your accident/injury occur? _____

_____

_____

Where did your accident/injury occur? _____

_____

_____

How did your accident/injury occur? _____

_____

_____

Will this accident/injury involve litigation currently or in the future? _____

_____

_____

Signature: _____ Date: _____

Thank you for your assistance.