

**SAN DIEGO ORTHOPAEDIC ASSOCIATES
MEDICAL GROUP, INC.**

PATIENT HEALTH QUESTIONNAIRE

PATIENT'S NAME: _____ **AGE:** _____ **DATE:** _____

What are you seeing the doctor for? _____

Date of injury? _____ Did this injury happen while at work? { }yes { }no

Who may we thank for referring you to our practice? _____

Are you being treated for any other medical problems? { }yes { }no If yes – What?

Height? _____ Weight? _____

Are you { } **right-handed**, { } **left-handed** or { } **ambidextrous**

List any **allergies** to any medications: _____

List your **current medications**: _____

Primary Care Physician { }yes { }no If yes, who? _____

yes no

{ } { } Do you **smoke?** – If yes, how much?

{ } { } Do you **drink alcohol?** – If yes, how much?

{ } { } If female – Is there any possibility that you are pregnant at this time?

What kind of **operations** have you had? (When?) { } **None**

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Do you have or have you had?

yes	no		yes	no		yes	no	
{ }	{ }	Angina, chest pain	{ }	{ }	Mitral valve prolapse	{ }	{ }	Thyroid disease
{ }	{ }	Heart "attack"	{ }	{ }	Severe headaches	{ }	{ }	Diabetes
{ }	{ }	Irregular heart beat	{ }	{ }	Asthma	{ }	{ }	Epilepsy, stroke
{ }	{ }	High blood pressure	{ }	{ }	Hepatitis	{ }	{ }	Kidney disease
{ }	{ }	Heart disease	{ }	{ }	Bleeding disorder	{ }	{ }	Drug addiction
{ }	{ }	Cancer	{ }	{ }	Lung Disease	{ }	{ }	Other _____

Does any member of your family have or have they ever had?

{ }	Arthritis	{ }	Heart Disease	{ }	Diabetes	{ }	Blood Disorders
{ }	High Blood Pressure	{ }	Muscular Disease	{ }	Cancer		