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INTERVENTIONAL PAIN MANAGEMENT

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ESTABLISHED 1947

**San Diego Orthopaedic Associates
PATIENT HEALTH QUESTIONNAIRE**

NAME : _____ **DATE :** _____
BIRTHDATE : _____ **AGE :** _____

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

Current Problem:

What are you seeing the doctor for today? _____

When did the problem start? _____

How did the problem start? _____

What symptoms are you experiencing?

YES NO

Pain If yes, what makes the pain better? _____, worse? _____

Swelling

Other _____

Have you ever had any problems with or injuries to the body part or parts for which you are seeing the doctor today? Yes No

If yes, please explain: _____

Do you have a primary care physician? Yes No. If yes, who? _____

Would you like a report sent to your physician? Yes No.

Medical History:

Are you right-handed, left-handed, or ambidextrous?

What is your height? _____

What is your weight? _____

Have you ever had surgery or an operation? Yes No

If yes, what type of surgery or operation have you had and when?

Do you currently have, or have you ever had any of the following?

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (Type: _____)
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, seizures	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer, acid reflux disease
<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Depression or anxiety
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Blood clots, DVT			

Does any member of your family have, or has a family member ever had, any of the following?

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots, DVT
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Do you take any medications (prescription or over-the-counter)? Yes No

If yes, please list all medications and dosages:

_____	_____
_____	_____
_____	_____

Do you have any allergies to medications? Yes No

If yes, what medicines are you allergic to? What was your reaction?

Do you smoke or use nicotine products? Yes No Quit

If yes, how many cigarettes do you smoke per day? _____

Do you drink alcohol? Yes No

If yes, how many drinks do you have per week? _____

What is your occupation? _____

If you are a female, is there any chance that you could be pregnant at this time? Yes No

What type of sports or recreational activities do you enjoy?
