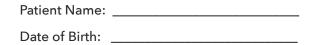


GOLDEN STATE ORTHOPEDICS & SPINE

HEALTH HISTORY

PLEASE COMPLETE THE FOLLOWII	NG INFOR	MATION FO	R REVIEW BY	YOUR PROVIDER.			
Name:		_ Birth Date	e:/	Age:			
Height: Weight:	ght: Weight:		1	Dominant Hand:	☐ Right ☐ Left		
Referring Provider:		Occupation:					
Email:			Phone	e:			
PATIENT MEDICAL HISTORY (mark a	ll that apply	<i>(</i>)					
☐ Acid Reflux ☐ Depress	Depression		;	Osteoporosis	Anemia		
☐ AIDS/HIV ☐ Diabete	☐ Diabetes		od Pressure	Sleep Apnea	☐ Enlarged Prostate		
Arthritis Drug Ab	Drug Abuse		Heart Beat	Liver Disease	☐ Heart Disease		
☐ Bleeding Disorder ☐ DVT (Blo	er DVT (Blood Clot)		isease	☐ Thyroid Disease	Other:		
☐ Cancer ☐ Fibromy	algia	Lung Disease		☐ Heart Attack			
Type & Year Gout		COPD		Stroke			
Atrial Fil	orillation	Seizure [Disorder	Asthma			
PREVIOUS SURGERIES & DATE(S):			NONE				
1.			2.				
3.			4.				
5.			6.				
IS INJURY WORK RELATED?	Yes 🔲 N	No If y	es, have you	filed a work comp cla	aim?		
FAMILY MEDICAL HISTORY (Mark if y	our immed	liate family mer	mbers (mom, d	lad, siblings) have any of	these conditions)		
☐ Alcoholism ☐ Bleeding ☐ Diabetes			art Disease	☐ Kidney D	isease Seizures		
Arthritis Cancer	Arthritis Cancer Gout High Blood Pressure Mental Illness Stroke						
DO YOU EXERCISE REGULARLY?	Yes	□ No □	escribe:				
TOBACCO USE:		□ No □	escribe:				
ALCOHOL CONSUMPTION:		Yes ☐ No If Yes: ☐ Daily ☐ Weekly ☐ Occasionally ☐					
RECREATIONAL/DRUG USE:		□ No T	ype/Amount	/Frequency:			
ALLERGIES: (If yes, please list)		□No					
Latex Allergy/Sensitivity		□No					
Metal Allergy Ye		□No					
Shellfish Allergy		□No					
Medication/Food Alle		Reaction					
	1						





GOLDEN STATE ORTHOPEDICS & SPINE

HEALTH HISTORY, CONTINUED

REVIEW OF SYMPIC	OMS (Recent or cui	rent condition:	s only)					
Constitutional	Constitutional		Cardiovascular				Metabolic/Endocrine	
NONE	Chills	NONE	Chest Pain	□N	NONE		NONE	
Fever	☐ Fatigue	Heart Murmur		□lto	☐ Itchy Skin		☐ Hair Loss	
☐ Night Sweats	Malaise	☐ Irregular H] Irregular Heart Beat		Rash		☐ Heat Intolerant	
Weakness		☐ Heart Palp	itations	SI	kin Infections		☐ Cold	d Intolerant
☐ Weight Gain ☐ L		Leg Swelli	Leg Swelling		Skin Lesions			
☐ Weight Loss ☐ F		☐ Fainting	Fainting		☐ Contact Allergy			
Head, Eye, Ear, Nose & Throat		Gast	Gastrointestinal		Neurological		Psychiatric	
NONE	□Vertigo	□NC	ONE		NONE			NONE
☐ Blurred/Double Vis	ion Uision Lo	ss 🗌 Ab	Abdominal Pain		Difficulty Walking			Anxiety
☐ Difficulty Swallowin	ng	☐ Co	☐ Constipation		Dizziness			□ Depression
Ear Drainage	Hematolog	gic 🗌 Fre	☐ Frequent Constipation		Poor Coordination			☐ Insomnia
☐ Facial Pain	□NONE	He	eartburn		Memory	Loss		
Headache	Bleeding	☐ Jai	undice		☐ Muscle V	Veakness		Reproductive
☐ Hearing Loss	Bruising	Lo	ss of Appetite		Tremors			NONE
☐ Nasal Congestion		□Na	usea		\Box Tingling			☐ Pregnant
Ringing in Ears		□Vo	miting					
Respiratory		Genito	urinary			Immunol	logical	
NONE		□NON	NONE		NONE			
☐ Cough		☐ Dys	Dysuria (Painful Urinatio			ion) 🗌 Asthma		
Dyspnea (Difficulty Breathing)		☐ Free	☐ Frequent Urination			Contact Dermatitis		matitis
Recent Infections		☐ Her	☐ Hematuria (Blood in Urine)) Environmental Allergies		
☐ Known TB Exposure		☐ Urg	Urge Incontinence			☐ Food Allergies		es
Wheezing		Urir	☐ Urinary Incontinence			Seasonal Allergies		
Shortness of Breath						☐ Bee Sting Allergies		
PREFERRED PHARM	ACY NAME:							
PHARMACY ADDRES	SS:							
PHARMACY PHONE	NUMBER:							
PATIENT SIGNATURE	≣:					DATE:		
EMAIL:		PHONE:						

Patient Name:	
Date of Birth:	



GOLDEN STATE ORTHOPEDICS & SPINE

HEALTH HISTORY, CONTINUED

PATIENT NAME:							
DATE OF BIRTH:		DATE:					
EMAIL:				PHONE:			
WHAT BODY PARTS ARE							
ON A SCALE OF 1 - 10 (1	'0 BEING WORST) , ŀ	HOW SEVERE IS YO	OUR PAIN?				
□0 □1 □2	□3 □4	<u></u>	7 🗌 8	□ 9 □ 10			
HOW WOULD YOU DES	CRIBE YOUR PAIN	۱?					
Sharp Dull	Stabbing	Throbbing A	ching 🔲 E	Burning 🔲 🤇	Constant	☐ Intermitte	ent
☐ Wakes me from sleep	·	Other:					
DO YOU HAVE:							
Swelling	Numbness	Tingling		Weakness		Bruising	
Other:							
HAVE YOU HAD ANY PH	YSICAL THERAPY	FOR THIS CONDIT	「ION?	☐ Yes ☐ No			
Location:		Da	tes:/_	/	_to	_//	
HAVE YOU HAD AN MRI	, CT OR X-RAYS F	OR THIS CONDITIO	N?	☐ Yes ☐ No			
Which study?	RI CT	☐ X-Rays					
Location:		Da	tes:/_	/	_ to		