Hiramoto Orthopaedic & Sports Medicine, PA

Medical History

Name: _____ **Date:**_____

Social Security Number: _____ **Age:**_____ **Date of Birth:**_____

Referring Doctor:_____ **Dr. Phone #:** _____

Location of Doctor:_____ **Male or Female**

Date of injury or onset:_____ **Right Handed or Left Handed**

Body Part to be examined by doctor (include **Rt** or **Lt** side) _____

Does injury involve a motor vehicle? Yes / No **Did this injury occur while working? Yes / No**

Give a brief description of symptoms, included how & when? _____

_____

Were X-Rays taken? _____ **If yes where**?_____

Is this a SECOND OPINION Yes / No **Have you seen other doctors for this problem? Yes / No**

LIST OF MEDICATIONS:		

Allergies:_____

Review of Systems

Circle if you have or had any of the following (it is important for the doctor to know when prescribing medications):

Heart Disease Lung Disease Stomach Problems Ulcers Urine Infections Diabetes Arthritis

High Blood Pressure Bleeding Tendencies Cortisone Medication Hepatitis A B C HIV

Describe all **circled** responses _____

List any surgeries _____

Social History

Work Status: __ Working Full or Part __Retired __Temp Disabled __Perm Disabled __Work in Home

__Student Employed by: _____

Have you missed work due to this problem? _____

Marital Status: __Single __Married __Divorced __Separated __Widowed

Smoking Currently No / Yes Packs per day _____ Quit Smoking_____ How Long _____

Alcohol consumption __Daily __Weekly __Monthly __Yearly

Family History

Reviewed by: _____ Date:_____

Member	*Alive/Deceased*	*Age*	*Health Status/Cause of Death*	*Member*	*Alive/Deceased*	*Age*	*Health Status/Cause of Death*
Grandfather (m)	A D			Mother	A D		
Grandmother (m)	A D			Sister/Brother	A D		
Grandfather (d)	A D			Sister/Brother	A D		
Grandmother (d)	A D			Sister/Brother	A D		
Father	A D			Sister/Brother	A D		

To be completed by staff: Height: _____Weight:_____Pulse:_____Initials: