RIDEOUT
ORTHOPEDIC CLINIC

**Medical History Questionnaire**

| Name: | Birthdate: | Left Handed ☐ Right Handed ☐ |
|---|---|---|
| Primary Doctor: | Referring Doctor: | MR#: |

**PRESENTING COMPLAINT/PROBLEM**

Reason for Visit:

| Injury? ☐ Yes ☐ No<br>Work Related? ☐ Yes ☐ No | Date of Injury: | Cause of Injury: |
|---|---|---|

Have you had any studies listed below pertaining to this visit?

| | | | |
|---|---|---|---|
| X-ray: | ☐ Yes | ☐ No | Where? |
| CT Scan: | ☐ Yes | ☐ No | Where? |
| MRI: | ☐ Yes | ☐ No | Where? |
| Bone Scan: | ☐ Yes | ☐ No | Where? |

**MEDICAL HISTORY**

| | | | | | |
|---|---|---|---|---|---|
| Rheumatoid Arthritis | ☐ Yes ☐ No | Where: | | | |
| Cancer | ☐ Yes ☐ No | Type: | | | |
| Glaucoma | ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Acid Reflux | ☐ Yes ☐ No |
| Hearing Loss | ☐ Yes ☐ No | Thyroid Disorder | ☐ Yes ☐ No | Ulcer Disease | ☐ Yes ☐ No |
| Migraines | ☐ Yes ☐ No | Adrenal Disorder | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No |
| Seizures | ☐ Yes ☐ No | Asthma | ☐ Yes ☐ No | Urinary Problem | ☐ Yes ☐ No |
| Stroke | ☐ Yes ☐ No | Emphysema | ☐ Yes ☐ No | Hepatitis | ☐ Yes ☐ No |
| Nerve Injury | ☐ Yes ☐ No | Tuberculosis | ☐ Yes ☐ No | Bowel Disease | ☐ Yes ☐ No |
| Mental Illness | ☐ Yes ☐ No | COPD | ☐ Yes ☐ No | High Blood Press | ☐ Yes ☐ No |
| Depression | ☐ Yes ☐ No | Heart Attack | ☐ Yes ☐ No | Phlebitis | ☐ Yes ☐ No |
| Bipolar Disorder | ☐ Yes ☐ No | Arrhythmia | ☐ Yes ☐ No | DVT/Clot | ☐ Yes ☐ No |
| Alcoholism | ☐ Yes ☐ No | Rheumatic Fever | ☐ Yes ☐ No | Anemia | ☐ Yes ☐ No |
| Osteoporosis | ☐ Yes ☐ No | Coronary Heart | | Bleeding Disorder | ☐ Yes ☐ No |
| AIDS | ☐ Yes ☐ No | Disease | ☐ Yes ☐ No | | |
| Social Drugs | ☐ Yes ☐ No | Serious Injury? | ☐ Yes ☐ No | Where: | |

**PREVIOUS SURGERIES/HOSPITALIZATIONS**

| Date: | Event: |
|---|---|
| Date: | Event: |
| Date: | Event: |

370 Del Norte Ave. #201
Yuba City, CA 95991
530-751-7201 office 530-751-2704 fax

RIDEOUT
ORTHOPEDIC CLINIC

## Medical History Questionnaire

| | |
|---|---|
| Date: | Event: |

### ALLERGIES (DRUG REACTIONS)

Are you allergic to any drugs or have you had any reactions to medications? ☐ Yes ☐ No

| | | |
|---|---|---|
| If Yes: | Drug: | Reaction: |
| | Drug: | Reaction: |
| | Drug: | Reaction: |

### FAMILY HISTORY

Has any immediate relative ever had:

| | | |
|---|---|---|
| Cancer | ☐ Yes ☐ No | Relative: |
| Diabetes | ☐ Yes ☐ No | Relative: |
| High Blood Pressure | ☐ Yes ☐ No | Relative: |
| Stroke | ☐ Yes ☐ No | Relative: |
| Heart Problems | ☐ Yes ☐ No | Relative: |
| Mother still alive? | ☐ Yes ☐ No | If no, age of death: Cause: |
| Father still alive? | ☐ Yes ☐ No | If no, age of death: Cause: |

### SOCIAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Presently living alone? ☐ Yes ☐ No

Stairs at home? ☐ Yes ☐ No

Occupation:

Retired? ☐ Yes ☐ No When:

Education: Completed grade:

Advanced Degree? ☐ Yes ☐ No

| | | | | | | |
|---|---|---|---|---|---|---|
| Alcohol Use: | ☐ Never | ☐ Rare | ☐ Occasional | ☐ Moderate | ☐ Heavy | ☐ Quit _____yrs. ago |
| Tobacco Use: | ☐ Never | ☐ Rare | ☐ Occasional | ☐ Moderate | ☐ Heavy | ☐ Quit _____yrs. ago |
| Drug Use: | ☐ Never | ☐ Rare | ☐ Occasional | ☐ Moderate | ☐ Heavy | ☐ Quit _____yrs. ago |

### REVIEW OF SYSTEMS

General Health: ☐ Good ☐ Average ☐ Fair ☐ Poor

| | | | | | |
|---|---|---|---|---|---|
| Fatigue | ☐ Yes ☐ No | Masses | ☐ Yes ☐ No | Swollen Glands | ☐ Yes ☐ No |
| Fever | ☐ Yes ☐ No | Skin Ulcers | ☐ Yes ☐ No | Nose Bleeds | ☐ Yes ☐ No |
| Chills | ☐ Yes ☐ No | Incontinence | ☐ Yes ☐ No | Gums Bleeding | ☐ Yes ☐ No |
| Sleep Disorder | ☐ Yes ☐ No | Hesitancy | ☐ Yes ☐ No | Claustrophobic | ☐ Yes ☐ No |
| Double Vision | ☐ Yes ☐ No | Burning/Urination | ☐ Yes ☐ No | Difficultly | |

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## Medical History Questionnaire

| | | | | | |
|---|---|---|---|---|---|
| Blurred Vision | ☐ Yes ☐ No | Urinary Frequency | ☐ Yes ☐ No | Swallowing | ☐ Yes ☐ No |
| Dizziness | ☐ Yes ☐ No | Blood in Urine | ☐ Yes ☐ No | Seizures | ☐ Yes ☐ No |
| Hearing Loss | ☐ Yes ☐ No | Lethargy | ☐ Yes ☐ No | Balance problems | ☐ Yes ☐ No |
| Sinus Pain | ☐ Yes ☐ No | Anxiety | ☐ Yes ☐ No | Appetite Changes | ☐ Yes ☐ No |
| Hoarseness | ☐ Yes ☐ No | Depression | ☐ Yes ☐ No | Abdominal Pain | ☐ Yes ☐ No |
| Ears Ringing | ☐ Yes ☐ No | Nervousness | ☐ Yes ☐ No | Constipation | ☐ Yes ☐ No |
| Skin rash | ☐ Yes ☐ No | Insomnia | ☐ Yes ☐ No | Diarrhea | ☐ Yes ☐ No |
| Lesions | ☐ Yes ☐ No | Bruise Easily | ☐ Yes ☐ No | Vomiting Blood | ☐ Yes ☐ No |
| Blood in Sputum | ☐ Yes ☐ No | Chest Pain | ☐ Yes ☐ No | Unexplained | |
| Blood in Stool | ☐ Yes ☐ No | Palpitation | ☐ Yes ☐ No | Weight Loss | ☐ Yes ☐ No |
| Productive cough | ☐ Yes ☐ No | Irregular Heart | | Metal in Body | ☐ Yes ☐ No |
| Shortness Breath | ☐ Yes ☐ No | Beat | ☐ Yes ☐ No | | |
| Blood Transfusions | ☐ Yes ☐ No | If Yes, when: | | | |

**Not including this visit's problem, are you experiencing:**

| | |
|---|---|
| Muscle Pain | ☐ Yes ☐ No |
| Joint Pain | ☐ Yes ☐ No |

Other Symptoms? Please specify:

| Patient/Parent/Guardian Signature | Date: |
|---|---|
| | |

**MEDICATION LIST:**

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# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Health Record Number: _____
Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

_____
Address _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where Appropriate)

_____
_____
_____
_____
_____
_____

4. This information may be disclosed to and used by the following individuals or organization:

_____
Address: _____
for the purpose of: _____

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or conditions: _____
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the Health Information Management Director - 749-4428 or Privacy Officer 751-4010.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

STOP! DO NOT WRITE HERE. NOTES IN MARGIN WILL NOT BE SCANNED INTO ELECTRONIC CHART.

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