Carlsbad Orthopaedic Group

Dr. Jon P. Kelly, M.D

Health History

Patient Name________________________

Chief Complaint____

Problem Began: _____/_____/_____ Is your problem: ☐ Work related? ☐ Auto Related?

Decribe your current problem and how it began:________________________________

____

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How often are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Using the pain scale below, please choose the number which best describes your pain:

	No Pain	1	2	3	4	5	6	7	8	9	10	Unbearbale Pain
What is your pain **RIGHT NOW**?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
What is your **TYPICAL** or **AVERAGE** pain?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
What is your pain **AT ITS WORST**?		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

What makes it worse?____

What is your pain **AT ITS BEST**?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

What makes it better?____

Pain Scale

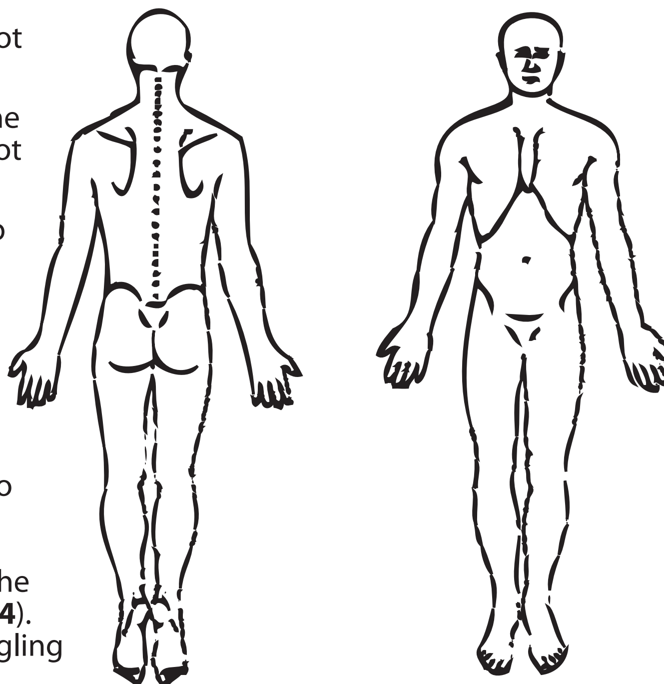
0-1 **Minimal:** The pain is an annoyance but does not stop me from working.

2-3 **Slight:** I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop my from working.

5 **Moderate:** The pain causes a marked handicap in my ability to work but I can continue.

7-8 **Moderate To Severe:** The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.

10 **Severe:** The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.



Using the pain scale above, mark the areas of **PAIN** on the diagram to the right with a "**P**" and the pain level (i.e. **P-4**). Also, mark the areas of **NUMBNESS** with an "**N**" and Tingling with a "**T**".

List any other symptoms or health concerns you have:________________________________

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Patient's Name:______________________________ Date:______________

Allergies

Do you have any known drug, food, or environmental allergies?	Yes	No

Please list any allergies below:

Past Medical History

Do you have or have you had any of the following medical conditions?		
Hypertension (high blood pressure)	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Peptic ulcers (stomach or duodenal)	Yes	No
Kidney disease	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No
Thyroid disease	Yes	No
Osteoporosis	Yes	No
Arthritis	Yes	No

List other medical conditions you have below:

OB GYN for Women

Are you now pregnant?	Yes	No
How many children have you had?		
0 1 2 3 4 5 6+		

Past Surgical Procedures

List any surgical procedures you may have had in the past and your approximate age at the time:
Procedure

Current Medications

List any medications you are taking, including over-the-counter medications and supplements;		
Medication	**Dose**	**How Often**

Family History

Have any of your blood relatives (living or deceased) had any of the following conditions?		
Hypertension (high blood pressure)	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Peptic ulcers (stomach or duodenal)	Yes	No
Kidney disease	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No
Thyroid disease	Yes	No
Osteoporosis	Yes	No
Arthritis	Yes	No

Social History

Which best describes your situation?
I live alone
I live with family
I live with friends
I live in a structured setting with help

What is your smoking history?
I have never smoked
I used to smoke
I currently smoke
How many packs a day?

What is your alcohol intake?
I do not drink alcohol
I used to smoke
I drink alcohol every day
I drink once or more each week
I drink rarely

Continue on back side

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Skin / Lymphatic

Rash	Yes	No
New skin spots	Yes	No
Skin infections	Yes	No
Change in a mole	Yes	No
Non-healing sores	Yes	No

Neurologic

Severe headaches	Yes	No
Fainting spells	Yes	No
Seizures and convulsions	Yes	No
Dizziness	Yes	No
Memory loss	Yes	No

Eyes

Vision problems	Yes	No
Glaucoma	Yes	No

ENT

Hoarseness	Yes	No
Nose bleeds	Yes	No
Hearing loss	Yes	No
Ringing in the ears	Yes	No
Difficulty swallowing	Yes	No
Tooth pain or infection	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid disease	Yes	No

Urologic

Burning with urination	Yes	No
Blood in urine	Yes	No
Frequency in urination	Yes	No

Allergies / Immune Disorders

Hay fever	Yes	No
Anaphylactic reaction	Yes	No
Rheumatoid disease	Yes	No
Other autoimmune disease	Yes	No

Gastrointestinal

Heartburn	Yes	No
Abdominal pain	Yes	No
Nausea	Yes	No
Jaundice	Yes	No
Bloody stool	Yes	No
Black stool	Yes	No

Musculoskeletal

Joint pain	Yes	No
Joint swelling	Yes	No
Back pain	Yes	No
Neck pain	Yes	No
Muscle pain	Yes	No

Hematologic

Easy bruising	Yes	No
Excessive bleeding	Yes	No

Constitutional

Chronic fatigue	Yes	No
Weight loss	Yes	No
Excessive weight gain	Yes	No
Fever	Yes	No
Night sweats	Yes	No

Cardiovascular

Chest pain	Yes	No
Racing heart beat	Yes	No
Poor circulation	Yes	No

Respiratory

Asthma	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
Persistant cough	Yes	No
Cough up blood	Yes	No

For office use:

Physician notes:____

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Patient Update

Date of Visit	Changes (Y/N)	Initials

Physician Review Dates

Date of Visit	Physician Signature

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