CALIFORNIA SPORT AND CARTILAGE INSTITUTE
GENERAL HISTORY

GREGORY T. HEINEN, M.D.

Please circle all that apply to your specific problem and/or provide the necessary information.

Name:_____ Age:_____ Date of Birth:_____

A. HISTORY OF PRESENT ILLNESS

1. Reason for being seen today:

a. Check the areas of your body that were injured or are painful

Head	Neck	Shoulders (R/L)	Elbows (R/L)
Wrist (R/L)	Hand (R/L)	Mid Back	Low Back
Hip (R/L)	Knee (R/L)	Ankle (R/L)	Feet (R/L)

b. When did it start? _____

c. Any numbness or tingling? yes/no

Where?_____

B. MEDICAL HISTORY

1. Past Surgery(ies)_____ Year:_____

_____ Year:_____

_____ Year:_____

_____ Year:_____

2. History of:

a. Hypertension Yes/No
b. Heart Disease Yes/No
c. Diabetes Yes/No
d. Tuberculosis Yes/No
e. Cancer Yes/No
f. Other_____

C. ALLERGIES TO MEDICATIONS:_____

D. CURRENT MEDICATIONS & ***Strength***:_____

_____

_____

_____

Patient Signature_____ Date:_____

Reviewed By:_____ Date:_____

E. PRESENT TREATMENT:_____

F. SOCIAL HISTORY:

1. Married, single, divorced
2. Number of Children:_____
3. Do You Smoke: CURRENT FORMER NEVER
4. Do you drink alcohol: Occasional, Rare, Never

G. FAMILY HISTORY

MEMBER	ALIVE	DECEASED	AGE	Health Status of Cause of Death
Grandmother(mom)	A	D		
Grandfather(mom)	A	D		
Grandmother(dad)	A	D		
Grandfather(dad)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

H. Are all of your immunizations up to date? YES/NO

I. If no, which immunizations are due? _____

REVIEW OF SYSTEMS

Are you currently having or have you had a problem with your

Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Digestion	No	Yes	_____
Bowel Movements	No	Yes	_____
Bladder Problem	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Bleeding Problems	No	Yes	_____
Balance Problems	No	Yes	_____
Numbness/Tingling	No	Yes	_____
Blackout/Fainting	No	Yes	_____
Psychological Problems	No	Yes	_____
AIDS	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Polio	No	Yes	_____
TB	No	Yes	_____
Epilepsy	No	Yes	_____

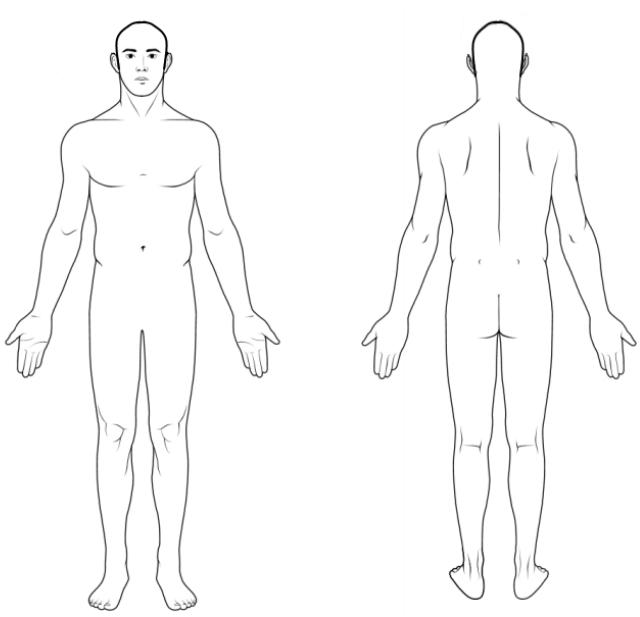
Patient Signature_____ Date:_____

Reviewed By:_____ Date:_____

Where is your pain now?

Mark ALL areas on your body where you feel any pain or numbness. Include ALL affected areas even if it was NOT caused by this injury.

Numbness	Pins and Needles	Burning	Stabbing
=====	ooooo	XXX	///



How bad is your pain?

Please circle the number showing how bad your pain is when it is at its best:

Best: (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

Please circle the number showing how bad your pain is when it is at its worst:

Best: (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain)

Patient Signature_____ Date:_____

Reviewed By:_____ Date:_____