ORTHOPEDIC GROUP
JOINT REPLACEMENT SPECIALISTS

7230 Medical Center Dr.
Suite 604
West Hills, CA 91307
Phone: 818.657-5640
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PLEASE COMPLETE THE FORM IN ITS ENTIRETY

Health Questionnaire

Date Completed_____

Name: _____ **MARITAL STATUS**: S/ M/ D/ W **AGE**:_____ **SEX**: M/ F

EMPLOYER:_____ **OCCUPATION**:_____

HEIGHT: _____ **WEIGHT:** _____**BIRTHDATE:** _____ **DOMINANT HAND:** L/ R

PRIMARY CARE PHYSICIAN/CITY: _____

HOBBIES:_____

DRUG ALLERGIES: NONE OR LIST (please circle one)

_____

CURRENT MEDICATIONS: NONE OR LIST (please circle one)

_____

TOBACCO: * NEVER SMOKED *FORMER SMOKER * CURRENT SMOKER: # OF PACKS PER DAY _____ (please circle one)

ALCOHOL: *NONE * RECOVERING ALCOHOLIC: # OF DRINKS PER WEEK _____ (please circle one)

SUBSTANCE/ DRUG ABUSE: *YES *NO * PRIOR HISTORY (please circle one)

PAST SURGERIES / ILLNESSES/ ACCIDENTS AND HOSPITALZATIONS: * NONE OR LIST (circle please)

_____

_____

_____

FAMILY HISTORY: Please circle

FATHER: Age _____ Living / Deceased * Allergies *Cancer * Tuberculosis *Diabetes *Heart disease *stroke

MOTHER: Age_____ Living / Deceased * Allergies *Cancer * Tuberculosis *Diabetes *Heart disease *stroke

SYSTEM REVIEW: Please circle if you have / had any of these conditions

- **GENERAL**: * Healthy * Ill * Recent Weight Gain _____ LBS, Loss _____ LBDS
- **HEART/ CIRCULATION**: * Normal * High Blood pressure *Heart Attack * Heart Failure * Angina *Arrhythmia * Poor Circulation
- **LUNGS** : * Normal * Asthma * Chronic Lung Disease * Blood Clots In Lung * Pneumonia
- **GASTROINTESTINAL** : * Normal * Reflux *Peptic Ulcer *Liver Disease
- **URINARY TRACT** : * Normal * Bladder Infection * Prostate Enlargement * Frequent Urination * Kidney Stones * Kidney Failure

- **ENDOCRINE :** *Normal * Diabetes * Thyroid Abnormality * Other
- **HEMATOLOGIC**: * Normal * Blood Clots * Transfusion – Your own Blood , OR Donor Blood * Abnormal Bleeding Tendencies
- **NEUROLOGIC** : *Normal * Stroke * Seizures * M.S * Depression
- **MUSCLES & JOINTS** : * Normal * Osteoarthritis *Rheumatoid * Fibromyalgia * Gout
- **HEAD & NECK :** * Normal * Headaches * Sinus Problems *Hearing Loss *Visual Loss
- **SKIN :** * Normal * Cancer * Psoriasis * Eczema * Rashes
- **INFECTIOUS DISEASE:** * None *Hepatitis A/ B/ C * HIV *Tuberculosis
- **CANCER :** * None * Yes , TYPE : _____
- **BONES :** * Normal * Osteoporosis * Fracture, YES , WHICH BONES _____

PHARMACY INFORMATION: Please provide your pharmacy information if available:

Pharmacy Name_____

Address (Cross Street and/or City) _____

Phone number _____

PLEASE USE THE SPACE BELOW TO EXPLAIN WHY YOU ARE SEEING THE DOCTOR. WHEN DID THE PROBLEM BEGIN AND WHAT ARE YOUR SYMPTOMS?