Tri-Valley Orthopedic Specialists, Inc.
Solving Musculoskeletal Problems Since 1985

Medical History

Date________________

Name:____ Age:________ M______ F_____

Have you or any member of your family been treated at Tri-Valley Orthopedics? ☐ Yes ☐ No ______________

Occupation:__________________ How Long:__________ Employer: ______________How Long: _______

Name of physician who requested that you contact TVO for this appointment (telephone # and location): _________

____

If you would like a letter sent to your family/primary care physician, please provide *name and location:* __________

____

Describe the problem and the DATE your symptoms began: Side affected ☐ Left ☐ Right ☐ Both

____

____ DATE SYMPTOMS BEGAN: ____________

Cause of problem? ☐ Car accident ☐ Work injury ☐ Sports injury ☐ Home ☐ Other______________

Who has given you treatment for this condition and what treatment did you receive? ________________

____

Have any tests been done? ☐ X-rays ☐ CT scan ☐ MRI ☐ EMG ☐ NCT ☐ Other: ___________

☐ Right-Handed ☐ Left-Handed Height:_________ Weight:_________

Have you had, or do you presently suffer from:

1. Seizures	☐ Yes	☐ No	12. Thyroid Disorder	☐ Yes	☐ No	23. Reaction to Anesthesia	☐ Yes	☐ No
2. Stroke	☐ Yes	☐ No	13. Depression	☐ Yes	☐ No	If yes, Reaction? ____________		
3. Cardiac/Heart problems	☐ Yes	☐ No	14. Anxiety	☐ Yes	☐ No	**24. Smoke Cigarettes**	☐ Yes	☐ No
4. High Blood Pressure	☐ Yes	☐ No	15. Blood Clots / Phlebitis	☐ Yes	☐ No	**How many years** ____________		
5. Respiratory problems	☐ Yes	☐ No	16. Bleeding Disorder	☐ Yes	☐ No	**Packs per day**____________		
6. Cancer	☐ Yes	☐ No	17. Difficulty Urinating	☐ Yes	☐ No	**Time since stopped**________**Years**		
If yes, Site______________			18. Kidney / Bladder Infection	☐ Yes	☐ No	25. Drink Alcohol?	☐ Yes	☐ No
7. Diabetes	☐ Yes	☐ No	19. Psoriasis / Skin rash	☐ Yes	☐ No	If yes? Amount ____________		
8. HIV	☐ Yes	☐ No	20. Have you had Cortisone?	☐ Yes	☐ No			
9. Hepatitis / Jaundice	☐ Yes	☐ No	If yes, Site:______________			26. Recreational Drugs?	☐ Yes	☐ No
10. GERD	☐ Yes	☐ No	21. Chemical Dependency	☐ Yes	☐ No	If yes, Name: ____________		
11. Ulcer / GI problems	☐ Yes	☐ No	22. Alcoholism	☐ Yes	☐ No	If yes, frequency:____________		

List any other medical problems not mentioned above: ______________________________

Please list ALL MEDICATIONS (prescription and non-prescription) that you are presently taking: __________

____

List ALL ALLERGIES: ____

List all past surgery (include dates if possible): ___________________________________

____

Any illnesses / medical conditions that "run" in your family? Father:______________ Mother:______________

Sister:__________________ Brother:__________________Other:_________________________.

PHARMACY – NAME / ADDRESS____

Patient Signature: ______________________________Physician Signature: ___________________