SAN DIEGO ORTHOPAEDIC ASSOCIATES
MEDICAL GROUP, INC.
PHYSICIANS AND SURGEONS

ACTIVE ASSOCIATES
LARRY D. DODGE, M.D.
CHRISTOPHER T. BEHR, M.D.
PETER B. WILE, M.D.
FRANZ J. KOPP, M.D.
DAVID W. FABI, M.D.
MANEESH BAWA, M.D.
BRYAN T. LEEK, M.D.

4060 FOURTH AVENUE, SUITE 700
SAN DIEGO, CA 92103
TELEPHONE (619) 299-8500
FACSIMILE (619) 297-1443

EMERITUS
FRANCIS E. WEST, M.D.
WALTER F. CARPENTER, M.D.
HOWELL E. WIGGINS, M.D.
WILLIAM S. MOWREY, M.D.
MICHAEL F. RODI, M.D.
WILLIAM C. McDADE, M.D.
WILLIAM H. DAVIDSON, M.D.
ROBERT M. AVERILL, M.D.

ESTABLISHED 1947

INTERVENTIONAL PAIN MANAGEMENT
KEVIN T. TOLIVER, M.D.

San Diego Orthopaedic Associates
PATIENT HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

BIRTHDATE: _____ AGE: _____

Whom may we thank for referring you to our practice? _____

Current Problem:

What are you seeing the doctor for today? _____
When did the problem start? _____
How did the problem start? _____

What symptoms are you experiencing?

YES **NO**

{ } { } Pain If yes, what makes the pain better? _____, worse? _____
{ } { } Swelling
{ } { } Other _____

Have you ever had any problems with or injuries to the body part or parts for which you are seeing the doctor today? { }Yes { }No
If yes, please explain: _____

Do you have a primary care physician? { }Yes { }No. If yes, who? _____
Would you like a report sent to your physician? { }Yes { }No.

Medical History:
Are you { } right-handed, { } left-handed, or { } ambidextrous?
What is your height? _____
What is your weight? _____

Have you ever had surgery or an operation? { }Yes { }No
If yes, what type of surgery or operation have you had and when?

_____

Do you currently have, or have you ever had any of the following?

YES	NO	YES	NO
{ }	{ } High blood pressure	{ }	{ } Cancer (Type:_____)
{ }	{ } Heart Disease	{ }	{ } Lung disease
{ }	{ } Asthma or emphysema	{ }	{ } Venereal disease
{ }	{ } Hepatitis or liver disease	{ }	{ } Bleeding disorder
{ }	{ } Diabetes	{ }	{ } Thyroid disease
{ }	{ } Epilepsy, seizures	{ }	{ } Stroke/TIA
{ }	{ } Kidney disease	{ }	{ } Arthritis
{ }	{ } Drug addiction	{ }	{ } Ulcer, acid reflux disease
{ }	{ } Gout	{ }	{ } Depression or anxiety
{ }	{ } High cholesterol	{ }	{ } Tuberculosis
{ }	{ } Skin problems	{ }	{ } HIV/AIDS
{ }	{ } Anemia	{ }	{ } Other_____
{ }	{ } Blood clots, DVT		

Does any member of your family have, or has a family member ever had, any of the following?

YES	NO	YES	NO
{ }	{ } Arthritis	{ }	{ } High blood pressure
{ }	{ } Muscular disease	{ }	{ } Heart disease
{ }	{ } Bone or joint disease	{ }	{ } Cancer
{ }	{ } Bleeding disorder	{ }	{ } Blood clots, DVT
{ }	{ } Diabetes	{ }	{ } Other_____

Do you take any medications (prescription or over-the-counter)? { }Yes { }No
If yes, please list all medications and dosages:

_____ _____
_____ _____
_____ _____

Do you have any allergies to medications? { }Yes { }No
If yes, what medicines are you allergic to? What was your reaction?

_____
_____

Do you smoke or use nicotine products? { }Yes { }No { }Quit
If yes, how many cigarettes do you smoke per day? _____

Do you drink alcohol? { }Yes { }No
If yes, how many drinks do you have per week? _____

What is your occupation? _____

If you are a female, is there any chance that you could be pregnant at this time? { }Yes { }No

What type of sports or recreational activities do you enjoy?

_____
_____