

**Drs. Anderson, Pietrobono, Haber and DellaMaggiore**

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NAME \_\_\_\_\_ DATE \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

EXPLAIN BRIEFLY WHAT BRINGS YOU TO THIS OFFICE: RIGHT [ ] LEFT [ ] \_\_\_\_\_

ARE ANY OF YOUR PRESENT PROBLEMS RELATED TO ANY INJURY? YES [ ] NO [ ]  
INDUSTRIAL [ ]

ARE YOU RIGHT HANDED [ ], OR LEFT HANDED [ ]?

**PAST MEDICAL HISTORY:**

1. HAVE YOU EVER HAD (Check the appropriate boxes and list year to the right.)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Measles                         | <input type="checkbox"/> Angina Pectoris    | <input type="checkbox"/> Pancreatitis         |
| <input type="checkbox"/> German Measles                  | <input type="checkbox"/> Heart Attack       | <input type="checkbox"/> Ulcerative Colitis   |
| <input type="checkbox"/> Chicken Pox                     | <input type="checkbox"/> Stroke             | <input type="checkbox"/> Crohn's Disease      |
| <input type="checkbox"/> Mumps                           | <input type="checkbox"/> Pericarditis       | <input type="checkbox"/> Sarcoidosis          |
| <input type="checkbox"/> Diphtheria                      | <input type="checkbox"/> Heart Murmurs      | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Rheumatic Fever                 | <input type="checkbox"/> High Cholesterol   | <input type="checkbox"/> Paget's Disease      |
| <input type="checkbox"/> Polio                           | <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Meningitis                      | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Cirrhosis            |
| <input type="checkbox"/> Tuberculosis (or positive test) | <input type="checkbox"/> Nephritis          | <input type="checkbox"/> Gallbladder Problems |
| <input type="checkbox"/> Valley Fever (or positive test) | <input type="checkbox"/> Kidney Stones      | <input type="checkbox"/> Epilepsy             |
| <input type="checkbox"/> Malaria                         | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Parasites                       | <input type="checkbox"/> Thyroid Disease    | <input type="checkbox"/> Pleurisy             |
| <input type="checkbox"/> Syphilis (or positive test)     | <input type="checkbox"/> Gout               | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Gonorrhea                       | <input type="checkbox"/> High Uric Acid     | <input type="checkbox"/> Hay Fever            |
| <input type="checkbox"/> AIDS, ARC (or positive test)    | <input type="checkbox"/> Gastric Ulcer      | <input type="checkbox"/> Chronic Bronchitis   |
| <input type="checkbox"/> Genital Herpes                  | <input type="checkbox"/> Duodenal Ulcer     | <input type="checkbox"/> Emphysema            |
| <input type="checkbox"/> Lyme Disease                    | <input type="checkbox"/> Bleeding Ulcer     | <input type="checkbox"/> Psychiatric Illness  |
| <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Alcoholism           |
|  |   | <input type="checkbox"/> Drug Addiction       |

2. PLEASE LIST IN CHRONOLOGICAL ORDER ALL HOSPITALIZATIONS, SERIOUS ILLNESSES, OPERATIONS, SEVERE INJURIES, AND BROKEN BONES (use back of page is necessary).

CONDITION/OR OPERATION	DATE	HOSPITAL	CITY/STATE	DOCTOR

3. PLEASE LIST ALL MEDICATION THAT YOU ARE CURRENTLY TAKING.

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

4. PLEASE LIST ALL MEDICATIONS THAT YOU ARE ALLERGIC TO.

MEDICATION	TYPE OF REACTION	MEDICATION	TYPE OF REACTION

5. PLEASE LIST ALLERGIES OTHER THAN DRUG RELATED: \_\_\_\_\_  
 \_\_\_\_\_

6. SOCIAL HISTORY:

Work: Hours per week \_\_\_\_\_ Occupation \_\_\_\_\_ Have you missed work due to this injury? YES , NO . If yes, please explain: \_\_\_\_\_  
 Date last worked \_\_\_\_\_ Date returned to part-time work \_\_\_\_\_, full-time work \_\_\_\_\_  
 Birthplace \_\_\_\_\_ Ethnic Origin \_\_\_\_\_  
 How long have you been in Santa Clara County? \_\_\_\_\_ Who do you live with? \_\_\_\_\_  
 Do you exercise regularly? \_\_\_\_\_ Do you follow a special diet? \_\_\_\_\_  
 Do you smoke? \_\_\_\_\_ How much per day? \_\_\_\_\_ Alcohol use: Daily  Occasionally  Rarely  Never

7. FAMILY HISTORY (Please list each member separately).

HAS ANY BLOOD RELATIVE HAD: (Please list who)

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Birth Defects       | <input type="checkbox"/> Blood Disorders     |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Drug Addiction      | <input type="checkbox"/> Glaucoma            |
| <input type="checkbox"/> Gout          | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hip/Spine Fractures |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Lupus             | <input type="checkbox"/> Osteoarthritis      | <input type="checkbox"/> Osteoporosis        |
| <input type="checkbox"/> Psoriasis     | <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Spondylitis         | <input type="checkbox"/> Stomach Ulcers      |
| <input type="checkbox"/> Stroke        | <input type="checkbox"/> Tuberculosis      |  |  |

RELATIVE	AGE	HEALTH	IF DECEASED, CAUSE OF DEATH	AGE AT DEATH
FATHER				
MOTHER				
BROTHER				
SISTER				
SON				
DAUGHTER				

### 8. ARE YOU TROUBLED WITH?

#### GENERAL

- Fever
- Shaking/chills
- Excessive/unusual fatigue
- Recurrent Infections
- Swollen glands
- Nervousness
- Suicidal ideas
- Difficulty sleeping
- Any other medical problems

#### EYES

- Impaired/Changing Vision
- Double vision
- Persistent dry eyes
- Eye inflammation
- Glaucoma
- Cataracts
- Glasses
- Do you use artificial tears?

#### EARS

- Deafness
- Ringing in ears
- Hearing aid

#### NOSE

- Sinus trouble
- Nose bleeds

#### CARDIO-RESPIRATORY

- Shortness of breath
- Chest pain
- Cough
- Coughing up blood
- Leg swelling
- Palpitations

#### GASTRO-INTETINAL

- Difficulty swallowing
- Heartburn
- Nausea
- Vomiting
- Vomiting blood
- Abdominal pain
- Constipation
- Diarrhea
- Yellow jaundice
- Recent change in bowel habits
- Stools which are black/bloody

#### GENITO-URINARY

- Frequency of urination:  
times per day [ ] per night [ ]
- Burning with urination
- Blood in urine
- Urgency of urination
- Discharge from penis, when?
- Excessive vaginal discharge
- Difficult start/stop urine flow
- Rash/sores on genitals

#### SKIN

- Rash
- Psoriasis
- Lumps or nodules
- Skin sensitivity to sunlight
- Change in skin texture
- Easy bruising/bleeding
- Skin ulcers
- Abnormal hair loss
- Fingers turning white  
on exposure to cold

#### METABOLIC

- Unusual heat intolerance
- Unusual cold intolerance
- Excessive thirst
- Excessive urination
- Excessive appetite
- Loss of appetite
- Weight loss [], gain []
- Hot flashes

#### MUSCULOSKELETAL

- Neck pain
- Upper back pain
- Lower back pain
- Muscle pain/weakness
- Swollen joints, where? \_\_\_\_\_
- Painful joints, where? \_\_\_\_\_
- Morning stiffness, where?  
Hours before improvement?

**MOUTH**

- Mouth ulcers
- Persistent dry mouth
- Jaw pain with chewing

**THROAT**

- Hoarseness
- Sore throats

**MENSTRUAL HISTORY**

- Age at onset \_\_\_\_\_
- Duration of flow \_\_\_\_\_
- Days between periods \_\_\_\_\_
- Symptoms with periods \_\_\_\_\_
- First day of last period \_\_\_\_\_
- Number of pregnancies \_\_\_\_\_
- Number of children \_\_\_\_\_

**NEUROLOGIC**

- Headaches: migraine/sinus tension
- Numbness, burning, tingling? where? \_\_\_\_\_
- Loss of memory
- Loss of consciousness
- Dizziness

Please bring with you the names and addresses where pertinent medical records, laboratory tests and x-rays might be obtained.

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Patient Signature

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Date