Alpine Orthopaedic Medical Group, Inc. 2488 N. California Street – Stockton, CA 95204-5508
(209) 948-3333

PATIENT'S NAME ______________________________________ DATE ____________________
Last First Middle

BIRTH DATE ________________________ AGE _______ SEX: M F (Please circle one)

1. Are you in good health?................ YES NO
   A. Has there been any change in your general health within the last year?............... YES NO
2. Last Physical Examination:
3. Are you now under the care of a physician?........................... YES NO
   A. If so, what is the condition being treated?
4. Have you had any serious illness or operation?...................... YES NO
   A. If so, please describe:
5. Have you been hospitalized in the past five years?............................. YES NO
6. Have you had any previous injuries (auto accidents)?................ YES NO
   A. If so, when?
7. Do you have any disease or condition not listed above that you think I should know about?........... YES NO
   A. Cardiovascular disease (heart trouble), heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)?.......... YES NO
      1. Do you have chest pain upon exertion?................. YES NO
      2. Are you ever short of breath after mild exercise?............ YES NO
      3. Do your ankles swell?......... YES NO
      4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep?...... YES NO
   B. Low Blood Pressure?.............. YES NO
   C. Asthma or Hayfever?............... YES NO
   D. Hives or skin rash?................... YES NO
   E. Fainting spells or seizures?........ YES NO
   F. Diabetes?.............................. YES NO
   G. Hepatitis, Jaundice, or liver disease?...................... YES NO
   H. Arthritis?............................ YES NO
   I. Painful swollen joints?............... YES NO
   J. Fracture (or broken) any joints? YES NO
      1. If so, which bone and when?
   K. Dislocation of any joints?.......... YES NO
      1. If so, which joint and when?
   L. Bursitis?............................. YES NO
      1. If so, where and when?
   M. Neck or Back pain?................ YES NO
   N. Meningitis?........................... YES NO
   O. Do you have any congenital defects (birth defects)?................ YES NO
   P. Stomach ulcers?......................... YES NO
   Q. Kidney trouble?.......................... YES NO
   R. Tuberculosis?............................ YES NO
   S. Do you have a persistent cough or cough up blood?..................... YES NO
   T. Veneral disease?......................... YES NO
   U. Other:
8. Have you had abdominal bleeding associated with previous surgery or trauma?...................................... YES NO
   A. Do you bruise easily?.................. YES NO
   B. Have you ever had a blood transfusion?....................... YES NO
      If so, explain circumstances:
9. Do you have a blood disorder, such as anemia?............................. YES NO
10. Have you had surgery or x-ray treatment for tumor, growth, or other condition?............................ YES NO
    If so, please describe:
11. Are you taking any drugs or medicine? YES NO
    If so, name:
12. Are you taking any of the following:
    A. Antibiotics or sulfa drugs............ YES NO
    B. Anticoagulants (blood thinners)....... YES NO
    C. Medicine for high blood pressure.... YES NO
    D. Cortisone (steroids)..................... YES NO
    E. Tranquilizers............................ YES NO
    F. Aspirin................................... YES NO
    G. Insulin, Tolbutamide (Orinase), or similar drug.......................... YES NO
    H. Digitalis or drugs for heart........... YES NO
    I. Nitroglycerine.......................... YES NO
    J. Other:
13. Are you allergic, or have you reacted adversely to:
    A. Local anesthetics....................... YES NO
    B. Penicillin or other antibiotics.......... YES NO
    C. Sulfa drugs.............................. YES NO
    D. Barbiturates, sedatives, or sleeping pills........................... YES NO
    E. Aspirin................................... YES NO
    F. Iodine.................................... YES NO
    G. Other:
14. Are you pregnant?.......................... YES NO