Peter S. Birnbaum D.O., Orthopedics, Hand Surgery & Sports Medicine

Date:_____

Name:_____

DOB:_____**Age**:_____ **Sex**: □Male □ Female
□ Right-handed □Left-handed
Marital Status: S M W D
Do you smoke? □Yes □No
Packs/day_____
Alcohol: □None Drinks/day_____
Could you be pregnant? □Yes □No
Primary Care Physician:_____
Primary Care Phone:
Problem to be treated for today: □ Right □ Left
Shoulder Elbow Wrist Hand Hip Knee Ankle Foot
Date of Injury:_____
How did it
occur:_____

_____

_____

X-rays? □ Yes □ No
When?_____ Where?_____

Pain Problems (check those that apply)

□ None
□ Goes elsewhere
□ Dull
□ During Activity
□ Electrical
□ Knife-like
□ Shooting
□ Throbbing
□ Constant
□ Aching
□ Burning
□ At Night
□ After Activity
□ Sharp
□ Periodic
□ Spasmodic
□ Intermittent

Severity (0 none, 10 worst imaginable pain)_____

What makes pain worse?_____

_____

What relieves the pain?_____

_____

Other problems (check those that apply)

□ Tingling □ Dislocation
□ Popping □ Giving way
□ Grinding □ Tenderness
□ Numbness □ Paralysis
□ Soreness □ Stiffness
□ Limited range of motion
□ Swelling □ Weakness
□ Nausea □ Vomiting
□ Fevers □ Chills
□ Night Sweats
□ Malaise □ Weight loss
□ Anorexia □ Bladder problem
□ Bowel problems
□ Other_____

Occupation:(include before retirement)

_____

_____

Drug *allergies* & reactions: □ None

_____

_____

_____

Height:_____Weight:_____

Emergency Contact:

Name:_____

Phone #:_____
Do you authorize this office to discuss your care and treatment with your emergency contact? □ Yes □ No

Signed:_____

Date: ___/____/____

3010 W. Orange Ave, Suite 507, Anaheim, CA 92804 (714)995-1531, Fax (714)995-8194

Medical History/Problems

	Personal	Details	Family History	Details
High blood pressure	□Y □N	_____	□Y □N	_____
Heart problem/disease	□Y □N	_____	□Y □N	_____
Coronary artery disease	□Y □N	_____	□Y □N	_____
Heart attack	□Y □N	_____	□Y □N	_____
Diabetes	□Y □N	_____	□Y □N	_____
Anemia	□Y □N	_____	□Y □N	_____
Gout	□Y □N	_____	□Y □N	_____
Kidney disease	□Y □N	_____	□Y □N	_____
Bladder Trouble	□Y □N	_____	□Y □N	_____
Bleeding disorder	□Y □N	_____	□Y □N	_____
Asthma	□Y □N	_____	□Y □N	_____
Epilepsy/seizures	□Y □N	_____	□Y □N	_____
Stomach problems	□Y □N	_____	□Y □N	_____
Neurological problems	□Y □N	_____	□Y □N	_____
Stroke	□Y □N	_____	□Y □N	_____
Blindness/Glaucoma	□Y □N	_____	□Y □N	_____
Thyroid problems	□Y □N	_____	□Y □N	_____
Deafness	□Y □N	_____	□Y □N	_____
Mental illness	□Y □N	_____	□Y □N	_____
Ulcer	□Y □N	_____	□Y □N	_____
Bowel problems	□Y □N	_____	□Y □N	_____
Rheumatic fever	□Y □N	_____	□Y □N	_____
TB	□Y □N	_____	□Y □N	_____
Valley fever	□Y □N	_____	□Y □N	_____
Hepatitis (specify type)	□Y □N	_____	□Y □N	_____
Pneumonia	□Y □N	_____	□Y □N	_____
Arthritis	□Y □N	_____	□Y □N	_____
Phlebitis	□Y □N	_____	□Y □N	_____
Prostate problems	□Y □N	_____	□Y □N	_____
Emphysema	□Y □N	_____	□Y □N	_____
AIDS/HIV	□Y □N	_____	□Y □N	_____
Other	□Y □N	_____	□Y □N	_____

Hospitalizations:(excluding surgeries) □ **None**

Description:_____Year:____Hospital:_____
Description:_____Year:____Hospital:_____
Description:_____Year:____Hospital:_____
Description:_____Year:____Hospital:_____
Description:_____Year:____Hospital:_____

Surgeries: ☐ **None**

Description:_____Year:____Hospital:_____
Description:_____Year:____Hospital:_____
Description:_____Year:____Hospital:_____
Description:_____Year:____Hospital:_____
Description:_____Year:____Hospital:_____
Description:_____Year:____Hospital:_____

Please list all **medications & over the counter supplements** you are currently taking:

Name	Dose	Frequency	Reason

The above information is to the best of my knowledge and a true statement of my current physical condition.

Signed:_____ **Date**:_____

For office use:
Prescriptions given:

Date	Name	Refills		