Revised 5/5/2014

MEIER ORTHOPEDIC
SPORTS MEDICINE

Phone: 1.310.777.7845
Fax: 1.310.247.0342

Health Information History

Name: _____ **Date:** _____

ADULT ILLNESSES:		MEDICATION TAKEN:
High Blood pressure	☐	Medication: _____
Rheumatic arthritis	☐	Medication: _____
Osteoarthritis	☐	Medication: _____
Gout	☐	Medication: _____
Diabetes	☐	Medication: _____
Thyroid condition	☐	Medication: _____
Seizures	☐	Medication: _____
Liver disease	☐	Medication: _____
Heart attack	☐	Medication: _____
Stroke	☐	Medication: _____
Ulcers	☐	Medication: _____
Alcoholism	☐	Medication: _____
Other	☐	Medication: _____

Other medications, vitamins, supplements, herbs taken: _____

_____

ALLERGIES/ADVERSE REACTIONS (medication or other):

1. _____ **Reaction type:** _____
2. _____ **Reaction type:** _____
3. _____ **Reaction type:** _____

SURGERIES (date and body part):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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CHILDHOOD ILLNESSES: (please select)

☐ Measles ☐ Whooping cough ☐ Diphtheria ☐ Chickenpox
☐ Strep throat ☐ Mumps ☐ Polio ☐ Rheumatic Fever

ALL OTHER HOSPITALIZATIONS (date + reason):

1. _____ 2. _____

3. _____ 4. _____

FAMILY HISTORY

☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Cancer ☐ Gout
☐ Glaucoma ☐ Diabetes ☐ Epilepsy ☐ Bleeding Disorder ☐ Osteoarthritis
☐ Kidney Disease ☐ Thyroid Disease ☐ Rheumatoid Arthritis ☐ Osteoporosis
☐ Other (please specify): _____

SOCIAL HISTORY:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Your date of birth: _____ **Place of birth:** _____

Number of children you have: _____

What is your highest level of completed education? _____

Is English your first language? _____

How many hours do you sleep per night? _____

Do you exercise regularly since the injury? _____

What were your hobbies or recreational activities (before the injury)? _____

_____

What are your hobbies or recreational activities now (after the injury)? _____

_____

Please indicate any of the following that you use, state amount used, and the age that you began using it:

Caffeine: How much per day: _____ Age: _____

Alcohol: How much per day: _____ Age: _____

Tobacco: How much per day: _____ Age: _____