



MARIN
ORTHOPEDICS &
SPORTS MEDICINE

**Marin Orthopedics & Sports Medicine
PATIENT HISTORY FORM**

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Name _____ Date of Birth _____

How would you like to be addressed? _____

Age _____ Height _____ Weight _____ lbs. Male / Female

Referring Doctor/Person _____ Primary Care Physician _____

Did this injury occur while at work? Yes No
If yes, have you filed a claim with your employer/Worker's Compensation? Yes No
Do you anticipate litigation regarding your injury? Yes No

Why are you seeing the doctor today? _____

How did your injury occur? _____

Which side? Right Left Both Dominant hand? Right Left

How long have you had this problem? _____

Have you had any previous surgeries to this area? Yes No

Have you seen a doctor for this problem? Yes No Who? _____

Have you been treated with: Physical Therapy Chiropractor Acupuncture
 Massage Brace

X-rays taken? Yes No If so, where? _____

MRI taken? Yes No If so, where? _____

Current Symptoms: Pain Swelling Loss of motion Numbness/Tingling

Other _____

Have you tried or are you taking any medicine for this problem? Yes No

Ibuprofen (Motrin, Advil) Aleve/Naprosyn Tylenol Aspirin Celebrex
 Pain Killers (Vicodin, Darvocet, Tylenol w/ Codeine, Percocet) Cortisone/Steroid Injections

Other _____

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Are you unable to participate in daily activities or sports? Yes No

If so, what? _____

Please List ALL Previous Surgeries: _____

Please List ALL Current Medications:

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Do you take any herbal supplements? (Ginseng, Gingko Biloba, St. John's Wart, etc) Yes No

If so, what? _____

Are you allergic to fish, shellfish, iodine? Yes No

Are you allergic to any medicine? Yes No

If so, please list the medicine and reaction (i.e. rash, anaphylaxis, nausea, hives, etc).

Do you smoke? Yes No

If so, how many per day? _____ How long have you smoked? _____

Do you drink alcohol? Yes No If so, how often: Daily Occasionally Rarely

Marital Status: Single Married Divorced Widowed Other

Who do you live with? _____

Are you currently employed? Yes No Retired Disabled Student

What type of work do you do? _____

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PAST MEDICAL HISTORY

(Check the box if yes and please indicate year.)

- AIDS/HIV_____
- Angina_____
- Anxiety/Panic Attacks_____
- Arrhythmia_____
- Asthma_____
- Arthritis_____
- Rheumatoid_____
 - Other_____
- Balance Difficulty
- Birth Defects_____
- Blood Clots_____
- Pulmonary Embolism_____
- Blood Transfusion_____
- Bronchitis_____
- Cancer_____
- Depression_____
- Diabetes_____
- Emphysema_____
- Fibromyalgia_____
- Falls (recent)_____
- Fevers/Chills/Night Sweats_____

- Gout_____
- Headaches_____
- Migraine
- Heart Attack_____
- Heart Murmur_____
- Hepatitis_____
- High Blood Pressure_____
- Hypo or Hyperthyroid_____
- Incontinence
- Bowel/Bladder
- Lupus_____
- Osteoporosis_____
- Phlebitis_____
- Pneumonia_____
- Psychiatric Disorders_____
- Seizures_____
- Stroke_____
- Tuberculosis_____
- Urinary Tract Infections_____
- Walking Difficulty_____
- Weight Loss (recent)_____

Do you have a history of cancer of any kind? Yes No

If you answered yes to the previous question, please describe the type of cancer, the date of diagnosis and current treatment:_____

Any other medical conditions:_____

Patient Signature_____ Date_____

Physician Signature_____ Date_____