

WATSON CLINIC_{LLP}

Quality Healthcare for Every Generation

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Orthopaedics & Sports Medicine

MEDICAL HISTORY

Date: _____

PLEASE PRINT:

Name: _____ Age: _____ Sex: M F Race: _____

Health History of Patient	Yes	No
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease/Stones	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Previous Fracture	<input type="checkbox"/>	<input type="checkbox"/>

Explain YES Answers Below:

Prior Surgeries (w/Dates):

Current Medications/Dosage:

Allergies NONE

Social History

Most Recent Occupation: _____

Married Single
 Divorced Widowed

Number of Living Children _____

Presently living alone? _____

Smoking History: _____ packs/day

Alcohol: Never Occasional
 Past Problem Frequently Use

Family History Yes No

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Kidney Disease/Stones	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>

Explain YES Answers Below:

Parents/Siblings Cause of Death:

Review of Systems Yes No

Reading Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Vision Changes	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>
Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Fever/Chills	<input type="checkbox"/>	<input type="checkbox"/>
Heart/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>
Calf Cramps w/Walking	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Toothache	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Poor Bowel Control	<input type="checkbox"/>	<input type="checkbox"/>
Poor Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Hot/Cold Spells	<input type="checkbox"/>	<input type="checkbox"/>

Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Change	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN ONLY Yes No

Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Spotting	<input type="checkbox"/>	<input type="checkbox"/>

Athletic Activities: _____

Hand Dominance Right Left

PRESENT COMPLAINT:

Chief Complaint: _____

Since when? _____

Was there an injury? _____

Where is your pain? _____

Describe your pain:

Numb Pressure Sharp
 Dull Crampy Throbbing
 Locking Unstable
 Constant Intermittent

What makes symptoms . . .

Worse? _____

Better? _____

Previous Studies (X-ray, MRI, Blood Tests):

Prior Treatment:

Steroid Injection
 Oral Medication
 Surgery
 Physical Therapy
 Other (describe): _____

NEW PATIENT EXAM

Name: _____

PHYSICAL EXAM:

VS: WT: _____ HT: _____ PULSE: _____ TEMP: _____

GENERAL: WD/WN NAD

MSE: A & O

INSPECTION: (alignment/symmetry)

CARDIOVASCULAR: (swelling/erythema/warth/pulses)

PALPATION: (tenderness/effusion)

ROM: (pain/crepitus)

STRENGTH/TONE:

STABILITY:

NEURO: (DTRs/sensory)

SPECIAL TEST:

X-RAYS: (Date _____)

IMPRESSION:

PLAN:

DICTATION