<u>Medical History</u>

Height _______ Weight _______

What are your chief complaints/injuries? ______________________________

Have you had any previous X-Rays/ MRI for your current problem? YES NO

If yes, where (name of facility)? ______________________________

Have you had any previous surgeries or hospital admissions? YES NO

If yes, Explain ______________________________

Are you allergic to Latex? YES NO

Are you allergic to or have you had any reaction to any medications? YES NO

If yes, list the substance you are allergic to or had a reaction to. ______________________________

Are you currently taking any medications? **YES** NO **If yes, please list:**

Medication	Dosage	Medication	Dosage

Do you have any difficulty/ problems with any of the following? (Please circle all that apply)

Head Eyes Ears Nose Throat Lungs Asthma Ulcers Thyroid Bowels Kidneys Heart Diabetes Gallbladder High Blood Pressure Cancer Bruising or Bleeding Problem Blood Clots Severe Snoring

Other: ______________________________

If you circled any of the above please explain ______________________________

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Are you Claustrophobic? YES NO

Do you use Tobacco? YES NO Do you drink alcohol? YES* NO *Frequency? ______________

<u>CONSENT FOR TREATMENT IF PATIENT IS A MINOR</u>

I grant Monterey Joint Replacement and Sports Medicine the authority to administer treatment and perform such procedures as are deemed necessary for the above patient.

Print Name ______________________ Relationship to Patient ______________

Signature ______________________ Date______________

<u>ACKNOWLEDGMENT OF PRIVACY PRACTICES</u>

I herby acknowledge that I have received a copy of this office's privacy practices. I further acknowledge that a copy of the current notice will be posted in the reception area. I will be offered a copy of any amendment to this notice of privacy practices.

Signature ______________________ Date______________