Rodney Z. Wong, M.D., Inc.

MEDICAL HISTORY

Name: ____ **Date:** ____________________

DOB:_________________________ **Height**: ____________________ **Weight:** ___________________

Family Physician: _____________________________________ **Phone**: ___________________________

Pharmacy________________________________ **Phone:** __________________ **Fax:** ________________

Pharmacy Street & City; ____

Reason for this Visit: □Knee □Calf □Hip □Elbow □Collar bone □Shoulder □Wrist □Finger □Ankle □Foot □Forearm □Toe □Ribs □Other; ______________________________, □Left □Right o**nset date**: ___________

Symptoms:

□ Pain □Sharp □Dull □Intermittent □Burning □Throbbing □Aching □Cramping
□Warmth □Swelling □Pain with Range of motion
□Joint Locks up □Joint Gives out □Wake up at night with pain
□Limited Range of motion □Tingling □Numbness
□Other: ____

How did you injure the area? ____

Did you have any treatment/s? ____

Do you have images of the injured area? □Y □N Where were they done? _______________________________

Do you Smoke?: □Y □N **Packs/cigarettes per day:** ________ **Chew tobacco?: □Y □N How often:** ___________

Do you drink alcohol? □Y □N What kind? __________________________Glasses/Cans: __________________

Allergies: ____

Severity: □Very Mild □Mild □Moderate □Severe Allergy Reaction/s: □Rash □Hives □Other: ________________
Onset: □Unknown □Adulthood □Childhood ____

Current Medications: name______________________ dosage________________ frequency ___________

name______________________ dosage________________ frequency ___________

name______________________ dosage________________ frequency ___________

**** If you have additional medications, please provide a separate list ****

Have you been tested positive for any contagious diseases? □Y □N **If yes, explain;** _______________________

Medical History:

□Hypertension □Pregnancy/ Breast Feeding Other:
□Diabetes □High Cholesterol ______________________________
□Heart Disease □Stroke ______________________________
□Peptic Ulcer/Reflux □Rheumatoid Arthritis ______________________________

Past Surgical History:

□Heart Surgery □Hysterectomy Other:
□Appendix Removal □Carpal Tunnel Release ______________________________
□Total Replacement □Arthroscopy ______________________________
Knee / Hip / Shoulder Knee / Shoulder / Elbow ______________________________

Family History:

Mother = □Cancer □Diabetes □Heart □Stroke □Bleeding □Hypertension □TB □Other ________________
Father = □Cancer □Diabetes □Heart □Stroke □Bleeding □Hypertension □TB □Other ________________