South Texas Bone & Joint
601 Texan Trail, Suite 300
Corpus Christi, TX 78411
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Justin Klimisch, MD

Last Name _____ First Name _____ MI _____

Date of Birth: _____ **Age:** _____

Sex: ☐ Male ☐ Female **Height:** _____ **Weight:** _____

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other _____

How did you hear about our office?

_____

Medical History/Family History:

	You	Family	Explain
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No	_____
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	_____
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	_____
Asthma/Emphysema	☐ Yes ☐ No	☐ Yes ☐ No	_____
Cancer	☐ Yes ☐ No	☐ Yes ☐ No	_____
Stroke	☐ Yes ☐ No	☐ Yes ☐ No	_____
Gout/Pseudogout	☐ Yes ☐ No	☐ Yes ☐ No	_____
Gallbladder disease	☐ Yes ☐ No	☐ Yes ☐ No	_____
Kidney Problems	☐ Yes ☐ No	☐ Yes ☐ No	_____
Seizure/Neurologic Problems	☐ Yes ☐ No	☐ Yes ☐ No	_____
Stomach ulcers	☐ Yes ☐ No	☐ Yes ☐ No	_____
Skin Problems	☐ Yes ☐ No	☐ Yes ☐ No	_____
Bleeding problems/DVT	☐ Yes ☐ No	☐ Yes ☐ No	_____
Non-healing wounds	☐ Yes ☐ No	☐ Yes ☐ No	_____
Psychiatric problems	☐ Yes ☐ No	☐ Yes ☐ No	_____
Ears/nose/mouth/throat problem	☐ Yes ☐ No	☐ Yes ☐ No	_____
Gum disease/tooth abscess	☐ Yes ☐ No	☐ Yes ☐ No	_____
Prostate gland disorder	☐ Yes ☐ No	☐ Yes ☐ No	_____
Other	☐ Yes ☐ No	☐ Yes ☐ No	_____
Hx of MRSA	☐ Yes ☐ No	☐ Yes ☐ No	_____

Please list **ALL MEDICATIONS AND DOSAGES** that you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have any history of complications from surgery or anesthesia? ☐ Yes ☐ No

If yes, explain _____

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, explain _____
Other allergies _____

Surgical History:

Procedure | Date | Doctor & Hospital/Location

_____
_____
_____
_____
_____
_____
_____
_____
_____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Living Situation: ☐ Alone ☐ With others Current Occupation _____

Home: ☐ Single Story ☐ 2 (+) Story

Number of Children _____ Number still at home _____

Tobacco use: ☐ Yes ☐ No ☐ Former If yes, amount and type _____

Alcohol use: ☐ Yes ☐ No If yes, amount and type _____

Drugs: ☐ Never Type/Frequency _____

Exercise: ☐ Never ☐ Rarely ☐ Weekly ☐ Daily Type: _____

Primary care physician: _____

Other specialists: _____
_____
_____

Review of Systems: Do you now or have you had any problems related to the following systems in the last 3 months?

Constitutional Symptoms:

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Headache	☐ Yes	☐ No

Eyes:

Blurred vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Pain	☐ Yes	☐ No

Respiratory:

Sleep Apnea	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Short of breath	☐ Yes	☐ No
TB	☐ Yes	☐ No

Neurological:

Tremors	☐ Yes	☐ No
Dizzy spells	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No

Endocrine:

Excessive thirst	☐ Yes	☐ No
Too hot/cold	☐ Yes	☐ No
Tired/Sluggish	☐ Yes	☐ No
Weight Gain/Loss	☐ Yes	☐ No

Genitourinary:

Urine retention	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No
Frequency of urination	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No

GI:

Abdominal pain	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Change in Bowel Movements	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Frequent Diarrhea	☐ Yes	☐ No
Blood in Stool	☐ Yes	☐ No
Trouble swallowing	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No

Cardiovascular:

Chest pain	☐ Yes	☐ No
Swelling of hands/feet	☐ Yes	☐ No
Abnormal heartbeat	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No

Skin:

Rash	☐ Yes	☐ No
Boils	☐ Yes	☐ No
Itching	☐ Yes	☐ No

ENT:

Hearing loss	☐ Yes	☐ No
Ear Infection	☐ Yes	☐ No
Freq. nose bleeds	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No

Hematologic:

Hepatitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
HIV	☐ Yes	☐ No
Do you take coumadin?	☐ Yes	☐ No

Psychologic:

Are you generally satisfied with your life?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Anxiety disorder	☐ Yes	☐ No