

La Jolla Sports Orthopedic
John H. Serocki, M.D.

Name: _____ Age: _____

Height: _____ Weight: _____ Dominant Hand: _____

Occupation: _____

What symptoms are you having? _____

When did the symptoms begin: _____

If you had a specific injury, please describe how the injury happened? _____

If your symptoms developed gradually, please describe the activities that caused your symptoms: _____

Please describe any treatment you may have previously had for this condition: _____

If you have had previous symptoms or injuries involving the injured region, please describe: _____

Surgeries:

List Previous surgeries and dates if any:

Surgery:

Date:

_____	_____
_____	_____
_____	_____
_____	_____

Medications:

List of medication, the dosage and how frequently you take it:

Medication:

Dosage:

How Often:

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

Allergies:

List drug or substance and your reaction to it (Include any reactions to anti-inflammatory medicines such as Motrin or Aleve):

Substance:

Reaction:

_____	_____
_____	_____
_____	_____
_____	_____

Family History:

Note if your parents, brothers, or sisters have had any of these conditions:

Rheumatoid Arthritis: _____

Cancer: _____

Diabetes: _____

Carpal Tunnel Syndrome: _____

Bleeding Disorder: _____

List any serious (including car accidents) or injuries you have had: _____

If you smoke, list for how long and how many packs a day: _____

If you drink, describe how much you drink and how often: _____

Please describe any leisure activities (including sports or athletic services) that you participate: _____

