BENJAMIN BUSFIELD, M.D.
ORTHOPEDICS INITIAL HISTORY FORM

NAME: ____ DATE: ________________

DOB: _____________________ AGE: _______ REFERRED BY: ________________________________

Chief Complaint What are we seeing you for today?

____
____
____

Past Medical History Please check all that apply:

- ◻ Diabetes
- ◻ Heart Disease
- ◻ Cancer
- ◻ Abdominal Disease
- ◻ Other: ____________________________________
- ◻ High Blood Pressure
- ◻ Neurologic Disorders (seizure/stroke)
- ◻ Bleeding Disorders
- ◻ Rheumatoid Arthritis

Past Surgical History Please state date and type:

____
____
____

Family History Has anyone in your family ever had:

- ◻ Diabetes
- ◻ Heart Disease
- ◻ Cancer
- ◻ Abdominal Disease
- ◻ Anesthesia problems: _______________________
- ◻ High Blood Pressure
- ◻ Neurologic Disorders (seizure/stroke)
- ◻ Bleeding Disorders
- ◻ Rheumatoid Arthritis

	Living	Medical Problem
Mother	Y N	____________________
Father	Y N	____________________

Social History Please check all that apply:

- ◻ Smoke Packs/day: ____
- ◻ Alcohol Drinks/week: ____

Marital Status ◻ Single ◻ Married

Medications Please state doses and how often per day:

____
____
____

Allergies to Medication Please state medication and type of reaction:

____
____
____

Review of Systems Have you had any of the following recently?

Y	N		Y	N		Y	N	
◻	◻	Fever	◻	◻	Abdominal Pain	◻	◻	Anxiety
◻	◻	Weight Loss	◻	◻	Heartburn	◻	◻	Depression
◻	◻	Blurry Vision	◻	◻	Constipation	◻	◻	Insomnia
◻	◻	Vision Loss	◻	◻	Diarrhea	◻	◻	History of blood clots
◻	◻	Hearing Loss	◻	◻	Pain with urination	◻	◻	Easy bruising
◻	◻	Sore Throat	◻	◻	Blood in urine	◻	◻	HIV exposure
◻	◻	Dizziness	◻	◻	Frequent urination	◻	◻	Cancer

For Medical Staff – Do Not Write Below This Line

☐ I have reviewed the health history form with the patient in detail

☐ I have advised patient to follow up with appropriate physician Signature: ________________________

(925) 528 - BONE

Walnut Creek | 1808 San Miguel Dr. Walnut Creek, CA 94596

Antioch | 2350 Country Hills Dr. Suite B, Antioch, CA 94509

☐	☐	Chest Pain	☐	☐	Genital lesion	☐	☐	Numbness
☐	☐	Heart palpitations	☐	☐	Back pain	☐	☐	Tingling
☐	☐	Heart murmur	☐	☐	Joint stiffness	☐	☐	Blackouts
☐	☐	Cough	☐	☐	Seizures	☐	☐	Wheezing
☐	☐	Shortness of Breath	☐	☐	Loss of bowel/bladder control	☐	☐	None of the above

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Signature: ____________________________________

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