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PATIENT HISTORY

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NAME:						DATE:					
Referred By: (check box) <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Doctor <input type="checkbox"/> Attorney <input type="checkbox"/> Other Health Professional											
Name of Person / Physician making referral:											
Primary Care Physician / Family Doctor:											
Please describe the reason for your visit:						Body Part:			<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both		
Acute injury (new) <input type="checkbox"/> YES <input type="checkbox"/> NO				Chronic Symptoms (old) <input type="checkbox"/> YES <input type="checkbox"/> NO							
How did your symptoms begin: If sudden, describe onset:											
On a scale of 1 - 10 (10 being most severe) circle # that best describes your pain: 1 2 3 4 5 6 7 8 9 10											
Approximate date symptoms began OR date of injury:											
Resulting from: (check which applies) <input type="checkbox"/> Sports <input type="checkbox"/> Accident <input type="checkbox"/> Work Related <input type="checkbox"/> Involving Litigation											
Are symptoms: <input type="checkbox"/> constant <input type="checkbox"/> intermittent <input type="checkbox"/> worsening <input type="checkbox"/> improving											
Check all that apply: <input type="checkbox"/> pain <input type="checkbox"/> stiffness <input type="checkbox"/> swelling <input type="checkbox"/> instability <input type="checkbox"/> weakness <input type="checkbox"/> numbness / tingling											
What makes symptoms worse?											
What makes symptoms better?											
What previous or formal treatment have you had? (medications, therapy, surgery, injections, etc.)											
Were previous treatments helpful to any degree? If so, what?											
PAST SURGICAL HISTORY AND / OR HOSPITALIZATION											
Previous: Type of Operations or reason for Hospitalization:											
1.											Year:
2.											Year:
3.											Year:
Any previous fractures? (please explain): <input type="checkbox"/> YES <input type="checkbox"/> NO											
Any other serious injuries? (please explain) : <input type="checkbox"/> YES <input type="checkbox"/> NO											
MEDICAL INFORMATION											
Drug Allergies: Do you have any drug allergies? <input type="checkbox"/> YES <input type="checkbox"/> NO											
If YES, name the drug and the type of reaction. (example: rash, nausea, etc.) PLEASE BE SPECIFIC											
CURRENT MEDICATIONS: List any medications you are taking at this time. Includes such items as aspirin, vitamins, laxatives, calcium, etc.											
NAME OF DRUG	DOSAGE (include strength & number of pills per day)	How long have you taken this medication?	Please check: Helped?								
			A lot	Some	Not At All						