

25751 McBean Parkway  
Suite 200  
Valencia, CA 91355  
Phone (661) 253-3399  
Fax (661) 253-3999

## MEDICAL HISTORY ~ REVIEW OF SYMPTOMS



**Tarek Bittar, M.D.**  
Orthopedic Surgery & Sports Medicine

11550 Indian Hills Road  
Suite 351  
Mission Hills, CA 91345  
Phone (818) 256-1948  
Fax (661) 253-3999

<b>PATIENT NAME:</b>		<b>DATE:</b>			
<b>MEDICAL HISTORY / REVIEW OF SYMPTOMS</b>					
Please check if you have had a history of any of the following	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
<b>GENERAL</b>			<b>CARDIOVASCULAR</b>		
Are you currently pregnant?			Chest pain, Angina		
Diabetes			Heart Attach Myocardial Infection		
Stroke			Palpitations		
Kidney Disease			High Blood Pressure, Hypertension		
Ulcers			Shortness of Breath		
Asthma or Lung Disease			Ankle Swelling		
Cancer TYPE:			<b>HEMATOLOGIC</b>		
Fatigue			Anemia		
Weakness			Blood clots		
Fevers			Bleeding tendency		
Skin Problems / Disorders TYPE:			Easily bruised		
Rheumatic Fever			Circulatory problems		
Tuberculosis			Blood thinners (currently on?)		
Recent weight loss / gain. How much?			(If yes, type?)		
<b>BLOOD BORNE PATHOGENS</b>			Phlebitis		
HIV / AIDS			<b>MUSCULOSKELETAL</b>		
Hepatitis			Joint Pain		
Other			Joint Swelling		
<b>SITES OF INJECTION</b>			Muscle weakness		
Urinary			Muscle tenderness		
Dental			Morning stiffness		
Other			Arthritis / Osteoarthritis		
<b>NEUROLOGICAL</b>			Rheumatoid Arthritis		
Headaches			Bunions		
Dizziness			Osteoporosis		
Fainting			Previous bone density test?		
Memory Loss			Bone / Joint Infections		
Loss of consciousness			Gout		
Muscle Spasms			<b>PSYCHOLOGICAL</b>		
Numbness or tingling of hands / feet			Depression		
Blindness or trouble seeing			Anxiety disorder		
Deafness or trouble hearing			Other		
Seizures					
Other illness or diseases which are not listed? Please describe:					
<b>FAMILY HISTORY</b> - Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:					
Diabetes (sugar)			Abnormal bleeding tendencies		
Heart Disease			Rheumatoid Arthritis		
Anesthetic complications			Osteoarthritis		
Cancer TYPE:			Gout		
<b>SOCIAL HISTORY</b>					
What is your approximate weight?	Lbs.	Height?	Ft.	In.	
Occupation:		No. of years:		Job duties:	
Do you smoke? (circle one)	Yes	No	Past	If yes or past, how many packs per day?	How many years?
Are you (circle one)	right handed		left handed		
What is your principle support system? (example: spouse, family, friends, church)					
I, as the patient, state the information is correct and accurate to the best of my knowledge.			I have reviewed this information with this patient.		
_____			_____		
Patient / Guardian signature			Tarek Bittar, M.D.		