Dr. Darius E. Lin
22 Odessey Suite 270B
Irvine CA 92618
949-431-2668

HEALTH HISTORY

Name:____ Date:____________________

Height:_________________________ **Weight**:___________________ Date of Birth:________________________

Reason for the visit:____

____

Referred by: ☐ Friends ☐ Family ☐ Online ☐ Primary Care Physician ☐ Urgent Care ☐ Other: _____________________

Primary Care Physician: ___________________________________ Date of Last Visit: ____________________

If applicable, Cardiologist: _________________________________ Date of Last Visit: ____________________

Preferred Pharmacy: ____ Pharmacy Phone Number: _____________________________

Pharmacy Address: ____

Past Medical History

Do you have or have you ever had any of the following? (*check if yes*)

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma/Pulmonary Disease
- ☐ Autoimmune Disease
- ☐ Blood Clot
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Psychiatric History
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis

Other Conditions: ____

____

____

Past Surgical History: ____

____

____

List all medications and dosage currently taking, including blood thinners, supplements

____

____

____

____

List all allergies and reaction (*medications, food, metal*)

____

____

____

Have you ever smoked? ☐ YES ☐ NO If Yes, how much and how often________________________ If you quit, how long ago? __________________

Do you drink alcohol? ☐ YES ☐ NO If Yes, how many drinks a week? _______________________

If Yes, has anyone ever told you to cut down on your drinking? ☐ YES ☐ NO

Have you ever you used recreational drugs, including marijuana. ☐ YES ☐ NO If yes, please list ____

___________________________ Physician Initials

________________________ Date Reviewed

IRVINE ORTHOPEDICS
Empowering Motion

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Review of Systems

Do you CURRENTLY have any problems in the following areas?
…………If yes, please CIRCLE or provide details

	YES	NO
Constitutional Weight gain or loss Fatigue Weakness Fever	☐	☐
EYES Loss of vision Altered vision Itchy eyes	☐	☐
Ears-Nose-Mouth-Throat Loss of hearing Nosebleeds Sinus problem Sores in mouth Sore throats Difficulty swallowing	☐	☐
Cardiovascular Chest pain Irregular heart beat High blood pressure Difficulty breathing walking up stairs	☐	☐
Musculoskeletal Joint pain Morning stiffness Muscle weakness Back pain Joint swelling	☐	☐
Gastrointestinal Nausea Vomiting Abdominal pain Diarrhea Blood in stool Jaundice Constipation	☐	☐
Genitourinary Difficult urination Pain or burning urination Blood in urine Discharge from genital	☐	☐
Respiratory Shortness of breath Difficulty breating Wheezing Coughing Coughing up blood	☐	☐
Skin Easy bruising Rash, itching Hives Nodes and bumps Discolouration	☐	☐
Neurological Numbness Headache Dizziness Fainting spells Tremors Weakness Muscle spasm	☐	☐
Blood/Lymph Transfusion Swollen Glands Anemia Prolong bleeding Low blood count Leukemia/lymphoma	☐	☐
Psychiatric Depression Anxiety Disorientation Hallucination Disorientation	☐	☐
Endocrine Frequent urination Thyroid problems (fatigue, hair loss, hot/cold intolerance)	☐	☐
Allergic/Immunologic Infection Drug sensitivity Hives, itching	☐	☐

__________________ Physician Initials

__________________ Date Reviewed