

South Texas Bone & Joint

601 Texan Trail, Suite 300
Corpus Christi, TX 78411
Phone: 361 854 0811
Fax: 361 806 5040

Justin Klimisch, MD

Last Name First Name MI

Date of Birth: _____ Age: _____

Sex: () Male () Female Height: _____ Weight: _____

Race: () African-American () Asian () Caucasian () Hispanic () Other _____

How did you hear about our office?

Medical History/Family History:

	You	Family	Explain
Heart Disease	() Yes () No	() Yes () No	_____
High Blood Pressure	() Yes () No	() Yes () No	_____
Diabetes	() Yes () No	() Yes () No	_____
Asthma/Emphysema	() Yes () No	() Yes () No	_____
Cancer	() Yes () No	() Yes () No	_____
Stroke	() Yes () No	() Yes () No	_____
Gout/Pseudogout	() Yes () No	() Yes () No	_____
Gallbladder disease	() Yes () No	() Yes () No	_____
Kidney Problems	() Yes () No	() Yes () No	_____
Seizure/Neurologic Problems	() Yes () No	() Yes () No	_____
Stomach ulcers	() Yes () No	() Yes () No	_____
Skin Problems	() Yes () No	() Yes () No	_____
Bleeding problems/DVT	() Yes () No	() Yes () No	_____
Non-healing wounds	() Yes () No	() Yes () No	_____
Psychiatric problems	() Yes () No	() Yes () No	_____
Ears/nose/mouth/throat problem	() Yes () No	() Yes () No	_____
Gum disease/tooth abscess	() Yes () No	() Yes () No	_____
Prostate gland disorder	() Yes () No	() Yes () No	_____
Other	() Yes () No	() Yes () No	_____
Hx of MRSA	() Yes () No	() Yes () No	_____

Please list **ALL MEDICATIONS AND DOSAGES** that you are currently taking:

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

Do you have any history of complications from surgery or anesthesia? () Yes () No

If yes, explain _____

Do you have any allergies to medications? () Yes () No

If yes, explain _____

Other allergies _____

Surgical History:

Procedure	Date	Doctor & Hospital/Location

Social History:

Marital Status: Single Married Divorced Widowed

Living Situation: Alone With others Current Occupation _____

Home: Single Story 2 (+) Story

Number of Children _____ Number still at home _____

Tobacco use: Yes No Former If yes, amount and type _____

Alcohol use: Yes No If yes, amount and type _____

Drugs: Never Type/Frequency _____

Exercise: Never Rarely Weekly Daily Type: _____

Primary care physician: _____

Other specialists: _____

Review of Systems: Do you now or have you had any problems related to the following systems in the last 3 months?

Constitutional Symptoms:

Fever Yes No

Chills Yes No

Headache Yes No

Eyes:

Blurred vision Yes No

Double vision Yes No

Pain Yes No

Respiratory:

Sleep Apnea Yes No

Wheezing Yes No

Cough Yes No

Short of breath Yes No

TB Yes No

Neurological:

Tremors Yes No

Dizzy spells Yes No

Numbness Yes No

Paralysis Yes No

Endocrine:

Excessive thirst Yes No

Too hot/cold Yes No

Tired/Sluggish Yes No

Weight Gain/Loss Yes No

Genitourinary:

Urine retention Yes No

Painful urination Yes No

Frequency of urination Yes No

Kidney stones Yes No

GI:

Abdominal pain Yes No

Loss of appetite Yes No

Change in Bowel Movements Yes No

Nausea/vomiting Yes No

Frequent Diarrhea Yes No

Blood in Stool Yes No

Trouble swallowing Yes No

Heartburn Yes No

Cardiovascular:

Chest pain Yes No

Swelling of hands/feet Yes No

Abnormal heartbeat Yes No

Varicose veins Yes No

High blood pressure Yes No

Skin:

Rash Yes No

Boils Yes No

Itching Yes No

ENT:

Hearing loss Yes No

Ear Infection Yes No

Freq. nose bleeds Yes No

Bleeding gums Yes No

Sore throat Yes No

Hematologic:

Hepatitis Yes No

Anemia Yes No

HIV Yes No

Do you take coumadin? Yes No

Psychologic:

Are you generally satisfied with your life? Yes No

Do you feel depressed? Yes No

Anxiety disorder Yes No