JOHN KLEIN MD
ORTHOPEDIC SURGEON

HEALTH HISTORY

Reason for office visit today: _____

Is your problem the result of: Fall/Injury Motor Vehicle Accident Work-related accident

Date of injury/accident: _____

If you were in an MVA, do you have an attorney? If yes, please give attorney's name: _____

Have you had any studies such as an X-ray, MRI, EMG related to your problem? Yes / No

If yes, when and where were they done? _____

Do you have any metal in your body? If yes, please explain: _____

Do you have a pacemaker? Yes / No

List any medications you are currently taking:

Medication and Dosage:	Reason for Taking:

Are you allergic to any medication? Yes / No

If yes, please list medication and reaction:

_____
_____
_____
_____

REVIEW OF SYMPTOMS

Are you having or have you had problems with the following?

☐ Stroke	☐ Eyes	☐ Ears, Nose, Throat	☐ Lungs, Breathing	☐ Polio
☐ Digestion	☐ Bowel Movement	☐ Bladder Problems	☐ Diabetes	☐ TB
☐ High Blood Pressure	☐ Bleeding Problems	☐ Numbness/Tingling	☐ Blackout/Fainting	☐ Psychological Problems
☐ HIV/AIDS	☐ Cancer	☐ Arthritis	☐ Claustrophobic	

OTHER: _____

What is your: Height _____ Weight _____