

# JAMES S. HAMADA, M.D.

Orthopaedic Surgery  
Sports Injury and Disorders of the Spine

A Professional Corporation  
Diplomate, American Board of Orthopaedic Surgery  
Qualified Medical Examiner

DATE: \_\_\_\_\_

MR.    MRS.    MISS    MS    MALE    FEMALE

PATIENT: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
                    LAST                      FIRST                      INITIAL

ADDRESS: \_\_\_\_\_ TEL#: (    ) \_\_\_\_\_

SS#: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ TEL# (    ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DRIVER LISC# \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

NAME OF PERSON IN CASE OF AN EMERGENCY (NOT LIVING WITH YOU)

NAME: \_\_\_\_\_ TEL# (    ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NAME OF SPOUSE: \_\_\_\_\_

## INSURANCE INFORMATION

PRIMARY INS: \_\_\_\_\_ SECONDARY INS: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

CERTIFICATE #: \_\_\_\_\_ CERTIFICATE #: \_\_\_\_\_

GROUP #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

NAME OF REGULAR DOCTOR: \_\_\_\_\_ TEL# (    ) \_\_\_\_\_

NAME OF SPECIALIST: \_\_\_\_\_ TEL# (    ) \_\_\_\_\_

WHO REFERRED YOU TO THIS OFFICE \_\_\_\_\_

323 N. Praire Avenue, Suite 315  
Inglewood, CA 90301  
Tel: (310) 673-4571  
Fax: 673-4576

21350 Hawthorne Boulevard, Suite 274  
Torrance, CA 90503  
Tel: (310) 543-1391  
Fax: (310) 543-4924

PATIENT'S CHECK LIST FOR MEDICAL HISTORY

NAME \_\_\_\_\_ DATE \_\_\_\_\_

PAST SURGERIES: LIST ANY SURGERIES WITH APPROXIMATE AGE AT WHICH THEY WERE PERFORMED

ACCIDENTS: LIST ANY SERIOUS TYPE INJURIES, WITH APPROXIMATE AGE.

PAST ILLNESSES: LIST ANY CHILDHOOD OR ADULT SERIOUS PAST ILLNESSES WITH APPROXIMATE AGE.

FAMILY HISTORY: IF ANY OF THE FOLLOWING HAVE RUN IN YOUR FAMILY, CHECK APPROPRIATE BOX.

ALLERGIES  CANCER  TUBERCULOSIS  DIABETES  HEART DISEASE/STROKE

PLACE A CHECK MARK IN THE APPROPRIATE SQUARES IN THE FOLLOWING LISTS OF SYMPTOMS.

IF YOU HAVE A SYMPTOM IN THE PAST AND DO NOT HAVE IT NOW, CHECK THE SQUARE LIKE THIS

IF YOU ARE HAVING THE SYMPTOM AT THE PRESENT TIME, ENCIRCLE THE SQUARE LIKE THIS

1. HEAD AND NECK

- SEVERE HEADACHES...[] SEVERE HEARING LOSS...[] CHRONIC NOSE OBSTRUCTION...[]
DIZZY SPELLS...[] RINGING IN EARS...[] CHRONIC SORE TONGUE...[]
FAILING VISION...[] PAIN IN EARS...[] PERSISTENT SORE GUMS...[]
EYE PAIN...[] DISCHARGE FROM EAR...[] PROLONGED HOARSENESS...[]
DOUBLE VISION...[] REPEATED NOSEBLEEDS...[] PERSISTENT NECK RIGIDITY...[]
SEE "FLOATING LIGHTS"...[] TOOTHACHE AT PRESENT...[] SWELLINGS IN NECK...[]

2. HEART AND LUNGS

- CHEST PAIN ON EFFORT...[] SIT UP TO BREATHE EASY...[] HAVE NIGHT SWEATS...[]
SKIPPING HEART BEATS...[] HAVE CHRONIC COUGH...[] ANKLES SWELL...[]
DIFFICULT BREATHING...[] SPIT UP BLOOD...[] ANY HEART DEFECTS...[]

3. STOMACH AND INTESTINES

- CHRONIC ABDOMINAL PAIN...[] VOMIT BLOOD...[] ANY BLOOD FROM RECTUM...[]
PERSISTENT NAUSEA...[] SKIN TURN YELLOW...[] CLAY COLORED STOOLS...[]
HEARTBURN...[] ANY CHRONIC DIARRHEA...[] HABITUAL CONSTIPATION...[]
APPETITE LOSS...[] ANY BLACK TARRY STOOLS...[] HAVE HEMORRHOIDS...[]

4. URINARY TRACT, ECT.

- ANY EXCESS URINATION...[] PAIN WITH URINATION...[] PAINFUL MENSTRUATION...[]
ANY URINARY SHUTDOWN...[] ANY LEAKAGE OF URINE...[] EXCESS MENSTRUATION...[]
SCANTY URINATION...[] PASSED ANY STONES...[] BLEED BETWEEN PERIODS...[]
ANY BLOOD IN URINE...[] ANY BEDWETTING...[] ANY MISSED PERIODS...[]
EXCESS NIGHT URINATION...[] ANY RETENTION OF URINE...[] NUMBER OF PREGNANCIES...
NUMBER OF LIVING CHILDREN...[]

5. MUSCLES, JOINTS AND NERVES

- TINGLING SENSATIONS...[] ANY LIMITED MOTIONS...[] SPEECH DISTURBANCES...[]
ANY NUMBNESS...[] ANY JOINT TROUBLE...[] ANY SEIZURES...[]
DISTURBANCE IN WALKING...[] NERVOUS BREAKDOWN...[] ANY ALCOHOL PROBLEMS...[]
ANY MUSCLE JERKING...[] ANY STROKES...[] ANY DRUG PROBLEMS...[]
ANY PARALYSIS...[] ANY MEMORY LOSS...[] ANY MENTAL PROBLEMS...[]
ANY SHAKING...[] PERSONALITY CHANGES...[] ANY VARICOSE VEINS...[]

6. ALLERGIES

- ANY FOOD ALLERGIES...[] INHALATION ALLERGIES...[] ADHESIVE TAPE ALLERGIES...[]
ANY MEDICATION ALLERGY...[] ANY CONTACT ALLERGIES...[] SUBJECT TO SKIN RASHES...[]

IF THERE ARE ANY FOOD OR MEDICATION ALLERGIES, LIST BELOW WHAT THEY ARE.

IF THERE ARE ANY ADDITIONAL HEALTH FACTORS IN YOUR HISTORY OR IF ANY OF THE ABOVE POINTS NEED CLARIFYING USE THIS SPACE FOR ADDITIONAL COMMENTS.