Jeffrey D. Carter, M.D.
ORTHOPEDIC & SPORTS CLINIC OF MONTEREY

21 Upper Ragsdale Drive, Suite 100
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Phone Number: 831-648-8020
Fax Number: 831-648-8023

Medical Questionnaire

Who should we thank for referring you to our clinic?: _____

History of medical conditions:
(Please check all that apply**)**

1. **Diabetes ____**
2. **Hypertension (High blood pressure) ____**
3. **Hypotension (Low blood pressure) ____**
4. **Hypercholesterolemia (High cholesterol) ____**
5. **Hyperthyroldism ____**
6. **Hypothyroidism ____**
7. **Coronary Artery Disease ____**
8. **Heart Attack ____**
9. **Cardiac Arrhythmias ____**
10. **Stroke ____**
11. **Kidney/ Liver ____**
12. **Stomach Ulcer ____**
13. **Other Medical Conditions:**

_____
_____
_____

Medications you are currently taking:
(Please check all that apply**)**

1. **Aspirin ____**
2. **Coumadin (Warfarin) ____**
3. **Lovenox _____**
4. **Plavix ____**
5. **Any other blood thinners?**

_____
_____

6. **Please list all other medications you are currently taking and list reason for taking the medication:**

_____
_____
_____
_____
_____

Are you **allergic** or do you have an **allergic reaction** to the following:

1. Local Anesthesia (Novocain, etc.)? ___
2. Antibiotics? ___
3. Sedatives, Barbiturates? ___
4. Aspirin or Ibuprofen? ___
5. Codeine or other pain killers? ___
6. Latex or Rubber Products? ___
7. Other allergies or reactions? ___ Please list: _____
_____

Please list all previous surgeries as well as dates procedures were performed? _____
_____
_____

Please provide us with a brief history of what we are seeing you for today: _____
_____
_____

Have you received any treatment for this injury/illness? : YES / NO

Physical Therapy- How many sessions? _____ Where was it performed? _____

Injections? – Name of injection? _____ How many injections? _____

Medications?- Name of medication(s)? _____

Signature: _____Date: _____

Physician's Signature: _____ Date: _____