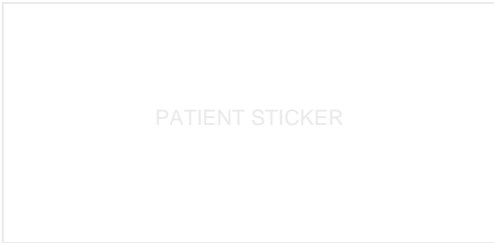


PATIENT INFORMATION SHEET

David R. McAllister, M.D.
UCLA Medical Center
Dept of Orthopaedic Surgery



(Please print)

1. Were you referred to this office?
 - If yes, who referred you?

2. Chief Complaint (what problem brings you in today?):

3. History of your Main Complaint:

4. Past Medical History (Any medical problems?):

5. Past Surgical History (Any surgery in the past?):

6. Current Medications:

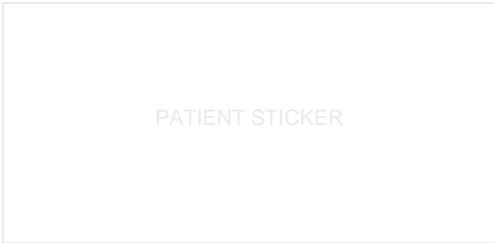
Allergies:

7. Social History:

- Do you smoke? Yes No If yes, how much per day?
- Do you drink alcohol? Yes No If yes, how much per day?

Occupation

Living Situation:



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8. Family History of Medical Problems (If yes, explain):

- Father: Yes No
- Mother: Yes No
- Grandparents: Yes No
- Siblings: Yes No

9. Any Medical Problems in the following areas? Yes No If yes, explain

- Constitutional symptoms: fever, weight loss, fatigue
- GI problems
- Eyes
- Ears, nose, throat
- Heart, circulation
- Bladder
- Breathing, lungs, shortness of breath
- Other miscellaneous problems
- Skin
- Nerves, coordination, neurological
- Psychological
- Endocrine
- Blood, lymphatics
- Immune problems
- Menstrual problems

David R. McAllister, M.D.