ILLINOIS BONE AND JOINT INSTITUTE, LLC

Today's Date: _____

Last IBJI Visit Date: _____

MEDICAL HISTORY FORM

PATIENT INFORMATION

Name (First) (Last) (Middle)

Age: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Height: _____ Weight: _____ lbs. BP _____

☐ R or ☐ L Handed

Occupation: _____

Working now? ☐ yes ☐ no ☐ retired ☐ disabled

REFERRING PHYSICIAN

Name

Street Suite

City State Zip Code

Phone

PREFERRED PHARMACY

Pharmacy: _____

Address: _____

Phone: _____

PRIMARY CARE PHYSICIAN (if different than above)

Name: _____

Address: _____

Phone: _____

HISTORY OF PRESENT ILLNESS

Reason for today's visit: _____

*If your visit is related to an injury, circle the appropriate response in the box below. If it is not related to an injury, skip this box.

The injury is due to: car accident / work injury / sports injury / fall / other _____

The injury occurred at: home / work / school / other _____

Are you off work due to the injury? Yes / No If yes, last day worked _____ If no, any restrictions _____

Is legal action / litigation pending due to this injury? Yes / No

DATE of onset / injury ___/___/___ **SYMPTOMS** _____

LOCATION of symptoms: _____ ☐ Right ☐ Left ☐ both ☐ NA

Circle each characteristic that best describes your problem:

QUALITY: Sharp / Dull / Throbbing / Aching / Burning / Cramping

SEVERITY: Mild / Moderate / Severe

DURATION: Infrequent / Intermittent / Constant / Hourly / Daily / Weekly

TIMING: During Activity / After Activity / Walking / Running / Stairs / Squatting / Pivoting / Overhead use / Throw / Lift / Other

CONTEXT: Improving / Worsening / Recurrent / More Frequent / Less Frequent / Unchanged

SYMPTOM RELIEF: Rest / Heat / Cold / Elevation / Physical Therapy / Brace / Injection / Medication / Other: _____

SYMPTOM AGGRAVATION: Activity / Position Change / Repetitive Motion / Fatigue / Other: _____

ASSOCIATED SYMPTOMS: _____

TREATMENT: Describe treatment and response for current problem _____

Have you had a problem with this area before? ☐ Yes ☐ No If yes, describe problem and prior treatment: _____

Have you had any diagnostic tests for this problem? ☐ Yes ☐ No If yes, what and where? _____

Do you have a copy of the test results? ☐ Yes ☐ No Did you bring them with you? ☐ Yes ☐ No

Has a physician recommended that you have surgery for this problem? ☐ Yes ☐ No

Name of previous treating physician(s), if any: _____

REVIEW of SYSTEMS:

Have you ever experienced or do you currently have any of the following signs or symptoms? If "Yes" please describe

SYMPTOMS	Yes	No	Describe all "Yes" responses
Eyes (e.g. blurred vision, double vision, loss of vision)			
Ears, Nose, Throat (e.g. sore throat, earache, ringing)			
Cardiovascular (e.g. chest pain, palpitations, ankle swelling)			
Respiratory (e.g. shortness of breath, cough, snore)			
Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)			
Genitourinary (e.g. burning, bleeding, or difficulty urinating)			
Musculoskeletal (e.g. joint, muscle, back or neck pain)			
Skin (e.g. delayed healing, rash, acne, cellulitis, psoriasis)			
Neurological (e.g. numbness, tingling, weakness)			
Mental Health (e.g. depression, anxiety, memory loss)			
Endocrine (e.g. weight gain/loss, excess thirst or urination)			
Hematologic (e.g. bruising, bleeding or clotting disorder)			
Allergic / Immunologic (e.g. rash, swelling, wheezing)			

PAST MEDICAL and FAMILY HISTORY:

Have you or a family member had problems with any of the following? Please indicate "Yes" with an "x" and indicate which family member

DISEASE / CONDITION	Self	Family	Describe all "Yes" responses
High Blood Pressure			
Diabetes Mellitus			
High Cholesterol			
Angina / MI / Cardiomyopathy			
Heart Valve Problem / Rhythm Problem			
Stroke / TIA / Seizures			
Asthma / COPD / Emphysema			
GERD / Ulcers / Colitis			
Hepatitis / Liver / Gall Bladder			
Kidney Failure / Stones			
Urinary Tract Infections / BPH			
Cancer			
Arthritis / Osteoporosis			
Bleeding / Clotting Disorder			
Anemia / Sickle Cell Anemia			
Thyroid / Endocrine Problem			
HIV / AIDS / TB			
Psychiatric / Mental Disorder			
Psoriasis / Eczema			
Other			

PAST SURGICAL HISTORY:

Procedure: _____ Surgeon: _____ Date: _____
Procedure: _____ Surgeon: _____ Date: _____
Procedure: _____ Surgeon: _____ Date: _____
Procedure: _____ Surgeon: _____ Date: _____

SURGICAL COMPLICATIONS: _____

ANESTHESIA: Have you ever had **problems with anesthesia?** ☐ Yes ☐ No If yes, please describe: _____

BLOOD: Have you ever had a blood transfusion? ☐ Yes ☐ No Do you have a history of blood clotting? ☐ Yes ☐ No

SLEEP APNEA: Do you have Sleep Apnea? ☐ Yes ☐ No Snore? ☐ Yes ☐ No Stop breathing during sleep? ☐ Yes ☐ No

MEDICATIONS (Prescription / Nonprescription / Herbal supplements / Vitamins / Other):

Medication	Dosage	How Long?	Side Effects

ALLERGIES: Please list type of allergy (medications, latex, food, metals, etc) and type of reaction you experience:

SOCIAL HISTORY:

Student ☐ Yes ☐ No School _____ Grade: _____ Sport: _____

Tobacco use ☐ Yes ☐ No Packs per day: _____ Current someday smoker ☐ Yes ☐ No

Pipe? ☐ Yes ☐ No Smokeless Tobacco? ☐ Yes ☐ No ☐ Quit Years Smoked _____

Alcohol use: ☐ never ☐ occasional ☐ daily ☐ heavy History of alcoholism? ☐ Yes ☐ No History of drug use? ☐ Yes ☐ No

Marital status: ☐ single ☐ married ☐ divorced ☐ widowed

Do you live alone? ☐ Yes ☐ No If no, who do you live with? _____

Are you pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No Date of last menstrual period? _____

Comments or Clarification: _____

Patient/Guardian Statement:

To the best of my knowledge, the above information is accurate and complete.

_____ / / _____
Patient Signature Date

_____ / / _____
Guardian Signature Date

_____
Guardian/Authorized Representative Printed Name

Provider Statement:

I have reviewed the questionnaire with the patient.

Any Changes

☐ Yes ☐ No _____ / / _____
Signed Date

☐ Yes ☐ No _____ / / _____
Signed Date

☐ Yes ☐ No _____ / / _____
Signed Date

☐ Yes ☐ No _____ / / _____
Signed Date