ILLINOIS BONE and JOINT INSTITUTE, LLC

*Name:* _____ */ MR#*_____

**Today's Date**: _____

## MEDICAL HISTORY FORM

**Last IBJI Visit Date:** _____

### PATIENT INFORMATION

_____
Name (First) (Last) (Middle)

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

Height: _____ Weight: _____ lbs ☐ Rt or ☐ Lt Handed

Occupation _____

### REFERRING PHYSICIAN

_____
Name

_____
Street Suite

_____
City State Zip Code

_____
Phone

Working now? ☐ yes ☐ no ☐ disabled ☐ retired If retired, what was your previous occupation: _____

### 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: _____

Have you had any of the following services this year (check all that apply):

Physical Therapy ☐ Occupational Therapy ☐ Chiropractic Services ☐ Home Health Services ☐

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## 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".

| DISEASE / CONDITION | Self | Father | Mother | Sibling | Child | Grand parent |
|---|---|---|---|---|---|---|
| Abnormal Heart Rhythm | | | | | | |
| AIDS | | | | | | |
| Anemia | | | | | | |
| Angina | | | | | | |
| Arthritis | | | | | | |
| Asthma | | | | | | |
| Bleeding Disorder | | | | | | |
| BPH (benign prostatic hyperplasia) | | | | | | |
| Cancer | | | | | | |
| Cardiomyopathy | | | | | | |
| Clotting Disorder | | | | | | |
| Colitis | | | | | | |
| COPD | | | | | | |
| Diabetes Mellitus | | | | | | |
| Eczema | | | | | | |
| Emphysema | | | | | | |
| Endocrine Problem | | | | | | |
| Gall Bladder Disease | | | | | | |
| GERD | | | | | | |
| Heart Valve Problem | | | | | | |

| DISEASE / CONDITION | Self | Father | Mother | Sibling | Child | Grand parent |
|---|---|---|---|---|---|---|
| Hepatitis | | | | | | |
| High Blood Pressure | | | | | | |
| High Cholesterol | | | | | | |
| HIV | | | | | | |
| Kidney Failure | | | | | | |
| Kidney Stones | | | | | | |
| Liver Problem | | | | | | |
| Mental Disorder | | | | | | |
| MI (myocardial infarction) | | | | | | |
| Osteoporosis | | | | | | |
| Psoriasis | | | | | | |
| Psychiatric Problem | | | | | | |
| Seizures | | | | | | |
| Sickle Cell Anemia | | | | | | |
| Stroke | | | | | | |
| Thyroid | | | | | | |
| TIA (transient ischemic attack) | | | | | | |
| Tuberculosis | | | | | | |
| Ulcer | | | | | | |
| Urinary Tract Infection | | | | | | |
| Other | | | | | | |

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**PAST SURGICAL HISTORY:**

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

**FOR MALE AND FEMALES AGED 65+:**

Have you had 2 or more falls in the past year or any fall with injury in the past year? ☐yes ☐no

Are you currently taking a Vitamin D supplement? ☐yes ☐no

Have you had a Dexa/Bone Density Study done in the past 5 years? ☐yes ☐no

If yes, were you told you have osteoporosis? ☐yes ☐no

If yes, are you taking prescription medication for osteoporosis? ☐yes ☐no

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

| **Medication** | **Dosage** | **Frequency** | **Route of Administration** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**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: Check all those that apply: ☐ Current every day smoker ☐ Current some day smoker **Year started smoking**_____

☐ Heavy tobacco smoker ☐ Light tobacco smoker

☐ Never smoker ☐Former smoker **Year Quit**_____

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 residing in a skilled nursing facility (SNF) either temporarily or permanently? ☐ yes ☐ no

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.

_____ ___/___/___

Signed Date