ILLINOIS BONE and JOINT INSTITUTE, LLC

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 ____________________

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: ____________________

ILLINOIS BONE and JOINT INSTITUTE, LLC

Name:__________________________ / MR#__________________

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			
Tuberculosis			
Psychiatric / Mental Disorder			
Psoriasis / Eczema			
Other			

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Name:_________________________ / MR#________________

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: _______ 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