MIDWEST BONE AND JOINT CENTER , P.C.

PATIENT MEDICAL HISTORY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

GENERAL PATIENT INFORMATION

Today's Date_____ Chart # _____

Full Name_____

Date of Birth_____ Age_____ O Male O Female

Primary Care Physician_____ Ht_____ Wt_____ BP_____ P_____

Email address_____ Pharmacy_____

Race: O White O African American O Hispanic O Multiracial O Other_____
Ethnicity: O Non Hispanic/Latino O Hispanic/Latino O Unknown O Patient Declined

Reason for today's visit

_____

_____

PAST MEDICAL HISTORY

1. Indicate any past medical conditions

O No significant medical history
O Alcoholism
O Anemia
O Aneurysm
O Anxiety Disorder
O Arthritis
O Asthma
O Blood Clots
O Breast Lump
O Cancer (type:_____)
O Cataracts/Glaucoma
O COPD/Emphysema
O Crohn's/Colitis
O Depression
O Diabetes otype I otype II
O Blood Disorder
O Diverticulitis
O Epilepsy
O Fibromyalgia
O Gallbladder Disorder
O Gout
O Hayfever
O Heart Attack MI
O Heart Disease
O Hemophilia
O Hepatitis oA oB oC
O Clotting Disorder
O Hernia
O Herpes
O High Cholesterol
O Other_____

O HIV/AIDS
O High Blood Pressure
O Hypothyroidism
O Hyperthyroidism
O Kidney Disease
O Lipid Disorder
O Liver Disease
O Lupus
O Migraine Headaches
O Multiple Sclerosis
O Obesity
O Osteoarthritis
O Osteopenia
O Osteopososis
O Peripheral Vascular disease
O Phlebitis
O Polio
O Prostate Problems
O Psoriasis
O Psychological Disorders
O Rheumatoid Arthritis
O Seizures
O Sickle Cell disease
O Skin Disease
O Stent (Date: _____)
O Stomach Ulcer
O Stroke(s) TIA
O Tuberculosis
O Venereal disease (STD)

PAST SURGICAL HISTORY

2. Have you had any surgeries?

O No O Yes

If yes, select from the list below.

O Knee Arthroscopy o left o right
O Total Knee o left o right
O Shoulder Arthroscopy o left o right
O Total Shoulder o left o right
O Total Hip o left o right
O Lumbar Disc (level_____)
O Lumbar Disc Fusion (level_____)
O Cervical Disc (level_____)
O Cervical Disc Fusion (level_____)
O Fractures (location_____)
O Appendectomy
O Adenoidectomy
O Bariatric
O Bowel Repair
O C-section
O Cancer Surgery
O Carpal Tunnel
O Cataracts/Lasix
O Gallbladder
O D&C
O Defibrillator
O Ear Tubes
O Ganglion cyst excision
OOther_____

O Heart Bypass
O Hernia Repair
O Hysterectomy
O Mastectomy
O Pacemaker
O Stents
O Thyroidectomy
O Tonsillectomy
O Transplant
O Tubal Ligation

_____

3. Did you have a difficult intubation/airway placement?

O No O Yes

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PATIENT MEDICAL HISTORY

ALLERGIES

4. Do you have any allergies or reactions?

O No known allergies
O Penicillin O Iodine
O Codeine O Lidocaine
O Sulfa O Steroids
O Latex O NSAIDs
O Tape O Aspirin
O Adhesives O IV Contrast Dye
O Cephalosporins (Keflex, Cephalexin)
O Tetracycline O Egg derived
O Other_____
O Other_____

SOCIAL HISTORY

5. Do you have any history of chemical dependency?

O No O Yes

6. Have you ever used any of the following street drugs?

O No use of illegal drugs
O Marijuana
O Methamphetamines
O Cocaine
O Heroin
O Other_____
O Other_____

7. Do you drink alcohol?

O No O Yes
If yes, what type?
O Hard liquor O Beer O Wine
Do you drink?
O 6 or more alcoholic beverages a day
O 4-5 alcoholic beverages a day
O 2-3 alcoholic beverages a day
O one alcoholic beverage a day
O less than one alcoholic beverage a day

8. Do you drink coffee, tea or soda?

O No O Yes
How many drinks per day? _____

9. Have you smoked tobacco?

O Never a smoker
O Former smoker
O Current everyday smoker
O Current someday smoker
If you smoke tobacco, how many packs per day?
_____
How many years have you smoked?_____
If former, how many years since quitting?____

10. Do you use chewing tobacco?

O No O Yes, # of year(s)_____

11. Did you serve in the military?

O No O Yes, # of year(s)_____

12. What is your level of education/school?

O Current Student
O Less than 12th grade
O High School
O GED
O College
O Trade/Vocational
O Post Graduate

13. What is your current marital status?

O Single O Married O Divorced
O Separted O Widowed

14. Do you live alone?

O No O Yes

15. Do you exercise on a regular basis?

O No O Yes, days per week_____

16. Are you currently employed?

O No O Yes, Occupation_____

17. If female, are you pregnant?

O No O Yes

18. Indicate any past testing you have had done for your current problem.

O x-rays O MRI O Bone Scan
O CT Scan O EMG O Ultrasound
O Lab Tests O Other_____

19. Have you had a cortisone (steroid) injection or have taken steroids in the past?

O no O 1 months ago
O 3 months ago O 6 months ago O year

20. Have you ever received a blood transfusion?

O No O Yes, date/why _____

21. Have you had a Bone Density study?

O No O Yes,
Date_____
Location_____

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MIDWEST BONE AND JOINT CENTER , P.C.

PATIENT MEDICAL HISTORY

FAMILY HISTORY

22. Indicate if any blood relatives have suffered any of the following? M=Mother F=Father

O Alcoholism M F
O Anemia M F
O Aneurysm M F
O Anxiety M F
O Arthritis M F
O Asthma M F
O Migraine M F
O Cancer M F
O Diabetes M F
O Epilepsy M F
O High blood pressure M F
O Blood clot/disorder M F
O Other _____
O Heart Disease M F
O Hepatitis A B C, M F
O Kidney Disease M F
O Lipid Disorder M F
O Mental Illness M F
O Osteoporosis M F
O Stroke M F
O Stomach Ulcers M F
O Thyroid Disease M F
O Glaucoma M F

REVIEW OF SYSTEMS

23. Select all of the problems you have had in the last 6 months?

O Appetite Poor
O Bloating
O Blood in Urine
O Blurred Vision
O Bruise Easily
O Chest Pain
O Chills
O Constipation
O Depression
O Diarrhea
O Difficulty swallowing
O Dizziness/Fainting
O Double Vision
O Earache/Discharge
O Excessive Thirst
O Fever
O Forgetfulness
O Headaches
O Hemorrhoids
O Hives
O Hoarseness
O Irregular Heartbeat
O Itching/Rash
O Lack of Bladder control
O Loose Teeth
O Loss of Hearing
O Nausea
O Nervousness
O Nosebleeds
O Numbness/Tingling
O Painful Urination
O Poor Circulation
O Persistent Cough
O Rectal Bleeding
O Ringing in Ears
O Sinus Problems
O Sores that won't heal
O Sweats
O Swelling of extremities
O Vomiting Blood
O Weakness

Please sign and date this form.

Signature *Date*

Reviewing Provider Signature *Date*

revised 2-26-15

MEDICATIONS

24. Please list all prescription and non-prescription medications you are currently taking including dosage and strength.

O None
O See attached Medication list

Medication	Strength	Each Day

Please return your completed form to the front desk.