PARKRIDGE BONE & JOINT

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Patient Name: _____ **DOB:** _____

MEDICAL HISTORY WORKSHEET

Please briefly tell us about your current problem or injury:

_____

_____

Please describe the reason we are seeing your today: _____

When did your first symptoms appear? (Provide date if known) _____

Is this a Workers' Compensation Injury/Claim? No ☐ Yes ☐

Is this a result of a motor vehicle accident? No ☐ Yes ☐

What were you doing when the first symptoms appeared? _____

On a scale of 1 – 10 how would you rate your pain? 1 2 3 4 5 6 7 8 9 10

Would you describe your current pain as: Mild ☐ Moderate ☐ Severe ☐ No Pain ☐

How many hours a day are your symptoms present? 2-4 ☐ 4-8 ☐ 8-12 ☐ >12 hours ☐

What makes your symptoms worse? _____

What makes your symptoms better? _____

Who is your primary care provider? _____
Address: _____ Phone: _____

Are you under the care of any specialist? If you are please list their name.
Name: _____ Name: _____
Name: _____ Name: _____

Which doctor referred you to us? _____
Address: _____ Phone: _____

Which is your local pharmacy? _____
Address: _____ Phone: _____

We will use this information to send updates to your Primary Care Provider and e-scribe your prescriptions as needed. Please remember to keep us updated if you have any changes.

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Patient Name: _____ DOB: _____

MEDICATION

If you are currently taking medication, herbs, or diet pills on a regular basis, please list their names:
I am not currently taking any prescription medicine ☐

Medication Name & Milligram	Medication Name & Milligram	Medication Name & Milligram
1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

ILLNESS

Please circle any serious illness you have now or have had in the past:

ADD/AHD	Coronary Artery Disease	Hypothyroidism
Anxiety/Depression	Prior MI/Heart Attack	MRSA Infection
Fibromyalgia	Hypertension	Tuberculosis
Gout/Pseudo Gout	Pacemaker/AICD	Kidney Disease
Lupus	MVP/Valve Disease	Kidney Failure/Dialysis
Osteoarthritis	Chronic Anemia/Blood Disorder	Latex Allergy
Psoriatic Arthritis	Chronic Leg or Foot Ulcers	Liver Disease/Hepatitis
Rheumatoid Arthritis	Chronic Migraines	Lymphedema
Mixed Connective Tissue Disease	Chronic Urinary Tract Infection	Metal Sensitivity
Unspecified Arthritis	Diabetes – Diet Controlled	Osteoporosis/osteopenia
Asthma/COPD/Emphysema	Diabetes –Non-Insulin Dependent	Seizure Disorder/Epilepsy
Bleeding Disorder	Diabetes – Insulin Dependent	Sleep Apnea
Blood Clots/DVT	Ulcers/Bleeding Ulcers	Stroke and/or TIA
History of Pulmonary Embolus	GERD/Reflux	Tetanus Vaccination
Cancer: Type:	Hernia	Peripheral Arterial Disease
Arrhythmia/Palpitations	High Cholesterol	Venous insufficiency
CHF/Heart Failure	HIV/AIDS	
Anything not listed?		

ALLERGIES:

If allergic to any medicines, please list the medication and its effect on you:
I have no allergies to any medication ☐

Medication Name	Effect
1.	
2.	
3.	
4.	

Medication Name	Effect
5.	
6.	
7.	
8.	

SURGERIES:

Please list all of your previous surgeries and approximate year/decade performed:
I have never had surgery ☐

Surgery	When
1.	
2.	
3.	
4.	

Surgery	When
5.	
6.	
7.	
8.	

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Patient Name: _____ DOB: _____

SOCIAL HISTORY:
Please tell us about yourself:
How tall are you? _____ How much do you weigh? _____

Which is your dominant (or writing hand)? Right ☐ Left ☐ Both ☐

How often do you drink alcohol beverages? None ☐ Occasional ☐ Moderate ☐ Heavy ☐

Do you use tobacco products? Yes ☐ Former Smoker ☐ No ☐
If Yes, Cigarettes ☐ Cigars ☐ Pipe ☐ Chew ☐ E-Cig ☐

How much a day? _____ Individual ☐ Packs ☐

What would you consider your exercise level: None ☐ Occasional ☐ Moderate ☐ Heavy ☐

What sports do you regularly participate? _____

Do you live alone or with someone? Spouse ☐ Child ☐ Parent ☐ Caregiver ☐

What is your highest level of education: High School ☐ GED ☐ Some College ☐ College Degree ☐

FAMILY HISTORY: PLEASE CHECK ALL THAT APPLY

Mother: _____ Alive _____ Deceased

____ Hypertension ____ Diabetes ____ Breast Ca ____ Coronary Artery Disease ____ Lung Cancer

____ Colon Cancer ____ Heart Attack ____ High Cholesterol ____ Asthma Cancer: _____

Father: _____ Alive _____ Deceased

____ Hypertension ____ Diabetes ____ Breast Ca ____ Coronary Artery Disease ____ Lung Cancer

____ Colon Cancer __ Heart Attack ____ High Cholesterol ____ Asthma Cancer: _____

Sister: _____ Alive _____ Deceased

____ Hypertension ____ Diabetes ____ Breast Ca ____ Coronary Artery Disease ___ Lung Cancer

____ Colon Cancer ____ Heart Attack ____ High Cholesterol ____ Asthma Cancer: _____

Brother: _____ Alive _____ Deceased

____ Hypertension ____ Diabetes ____ Breast Ca ____ Coronary Artery Disease ___ Lung Cancer

____ Colon Cancer ____ Heart Attack ____ High Cholesterol ____ Asthma Cancer: _____

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