MIDWEST BONE & JOINT INSTITUTE
MBJ

Date

MEDICAL HISTORY FORM

PATIENT INFORMATION

Name *(First) (Middle) (Last)* ◯ Male ◯ Female

Age **Date of Birth** **Right or Left handed?** ◯ Right ◯ Left

Working Status ◯ Working ◯ Retired ◯ Disabled

Occupation

PHYSICIANS

Referring Physician *(First) (Last)* **Telephone**

Primary Care Physician *(First) (Last)* **Telephone**

PREFERRED PHARMACY

Name, Address **Telephone**

MEDICAL INFORMATION

Chief Complaint *(Example: Right hip pain)*

Date of injury or onset of symptoms

Describe your symptoms *(Example: a sharp pain when I walk)*

How did the injury happen?

Symptom Relief *(Example: rest, heat/cold, therapy, medication)*

Symptom Aggravation *(Example: activity, movement)*

Additional Symptoms

Describe Treatment

Have you had any diagnostic tests for this problem? ◯ Yes ◯ No **If Yes, what & where?**

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

Name of previous treating physician(s), if any?

PAST MEDICAL HISTORY

PAST SURGICAL HISTORY *(Please list the surgical procedure, date of procedure and complications)*

Have you ever had problems with anesthesia? ◯ Yes ◯ No

If yes, describe:

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SOCIAL HISTORY

Student? ◯ Yes ◯ No

School _____ **Grade** _____

Sport _____

Marital Status ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Do you live alone? ◯ Yes ◯ No

Alcohol use ◯ Never ◯ Occasional ◯ Daily ◯ Heavy

History of alcoholism? ◯ Yes ◯ No

History of drug use? ◯ Yes ◯ No

FAMILY HISTORY

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

Medication Name	Dosage	Medication Name	Dosage

Are you taking low-dose Aspirin? ◯ Yes ◯ No

Are you taking Anti-coagulants? ◯ Yes ◯ No

Are you taking Corticosteroids? ◯ Yes ◯ No

Have you taken at least two different anti-inflammatory medications for your condition? ◯ Yes ◯ No

If Yes, how long? _____

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

RISK FACTORS

Tobacco use ◯ Never Smoked ◯ Former Smoker **Are you a current smoker?** ◯ Yes ◯ No

Height _____ **Weight** _____ **BP** _____ \ _____

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REVIEW of SYSTEMS *(Have or do you ever experience any of the following signs or symptoms? If yes please describe)*

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

COMMENTS OR CLARIFICATION

Patient/Guardian Statement:

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

Patient Signature _____ **Signed Date** _____

Guardian Signature _____ **Signed Date** _____

Guardian/Authorized Representative *(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** _____

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Account #

PATIENT INFORMATION

Name *(First) (Middle) (Last)* ◯ Male ◯ Female

Age **Date of Birth**

SSN **Marital Status** ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Address **City** **State** **Zip Code**

Home Telephone **Work Telephone** **Cell Telephone**

Email **Can we email you newsletters?** ◯ Yes ◯ No

Preferred Language **Ethnicity** ◯ Hispanic ◯ Non-Hispanic **Race**

PHYSICIANS

Referring Physician *(First) (Last)* **Telephone**

Primary Care Physician *(First) (Last)* **Telephone**

GUARANTOR

☐ Guarantor Same As Patient **Relationship** **Telephone** **Date of Birth**

Name *(First) (Middle) (Last)* ◯ Male ◯ Female

SSN **Occupation** **Employer**

Address **City** **State** **Zip Code**

PATIENT EMPLOYMENT AND EMERGENCY CONTACT

Employment Status ◯ Working ◯ Retired ◯ Disabled **Emergency Contact**

Occupation **Telephone**

Employer **Relationship**

INSURANCE CARRIERS

	Carrier #1	Carrier #2
Name		
Policy/Claim #		
Group ID		
Policy Holder		
Policy Holder DOB		

Work Related? ◯ Yes ◯ No

Work Comp Insurance **Work Comp Contact**

Insurance Address **Contact Telephone**

Claim #

Insurance Telephone

I hereby authorize Midwest Bone and Joint Institute to release any information to my insurance company acquired in the course of my examination or treatment. I hereby authorize benefits to be paid directly to them. I authorize them to check pharmacies for my prescription history. I understand I am responsible for any unpaid balance.

Sign *(Parent if Patient is a minor)*

Reset Form

Print Form

Date