



MEDICAL HISTORY FORM

Date _____

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:



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

Empty text box for 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)

Empty text box for allergies.

RISK FACTORS

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

Height _____ Weight _____ BP _____



Patient Name _____

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)	<input type="radio"/> Yes <input type="radio"/> No	
Ears, Nose, Throat (e.g. sore throat, earache, ringing)	<input type="radio"/> Yes <input type="radio"/> No	
Cardiovascular (e.g. chest pain, palpitations)	<input type="radio"/> Yes <input type="radio"/> No	
Respiratory (e.g. shortness of breath, cough, snore)	<input type="radio"/> Yes <input type="radio"/> No	
Gastrointestinal (e.g. ulcer, gastritis, GI bleed)	<input type="radio"/> Yes <input type="radio"/> No	
Genitourinary (e.g. burning, bleeding)	<input type="radio"/> Yes <input type="radio"/> No	
Musculoskeletal (e.g. joint, muscle, back or neck pain)	<input type="radio"/> Yes <input type="radio"/> No	
Skin (e.g. delayed healing, rash, acne, cellulitis)	<input type="radio"/> Yes <input type="radio"/> No	
Neurological (e.g. numbness, tingling, weakness)	<input type="radio"/> Yes <input type="radio"/> No	
Endocrine (e.g. weight gain/loss, excess thirst or urine)	<input type="radio"/> Yes <input type="radio"/> No	
Hematologic (e.g. bruising, bleeding, clotting disorder)	<input type="radio"/> Yes <input type="radio"/> No	
Allergic / Immunologic (e.g. rash, swelling, wheezing)	<input type="radio"/> Yes <input type="radio"/> 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 _____



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)* _____

Date _____

Patient Name _____

PLEASE SIGN & DATE:

Midwest Bone & Joint Institute's Privacy Policy has been made available to me in the office or via the website www.midwestbonejoint.com:

X _____ Date: _____
Patient Signature (Parent if patient is a minor)

CONFIDENTIAL COMMUNICATION REQUEST

May we leave a message regarding medical information, please circle your answer:

- | | | |
|-------------------------------|-----|----|
| On answering machine at home? | Yes | No |
| With person at your home? | Yes | No |
| On your voicemail at work? | Yes | No |
| On your email account? | Yes | No |
| In a cell phone text message? | Yes | No |

May we speak to a family member regarding your medical status? If so, with whom may we speak?

X _____
Patient Signature (Parent if patient is a minor)

May we speak to a family member regarding your financial status? If so, with whom may we speak?

X _____
Patient Signature (Parent if patient is a minor)

RELEASE OF LABORATORY & X-RAY INFORMATION

I hereby authorize Midwest Bone & Joint Institute to give lab, x-Ray, MRI, and CT results to a family member:

X _____
Patient Signature (Parent if patient is a minor)

ACKNOWLEDGEMENT REGARDING MEDICAL EQUIPMENT

Not all medical equipment may be paid for by my insurance company. We will let you know which items may not be covered. If my Insurance Carrier denies payment, I agree to be personally and fully responsible for payment.

X _____
Patient Signature (Parent if patient is a minor)



midwestbonejoint.com

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Elgin, IL 60123
847.931.5300

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Suite 140
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224.293.1170

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420 W. Northwest Highway
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847.382.6766

GENEVA
308 Randall Road
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630.262.5391

ALGONQUIN
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Suite 101A
Algonquin, IL 60102
847.854.8590