

LAKE FOREST ORTHOPAEDIC ASSOC. S.C.  
ILLINOIS BONE & JOINT INSTITUTE, LTD.  
MEDICAL HISTORY

Patient Name	Age	Date
Patient Account No.	Medical Alert	

1. Are you aware of having an allergic (or adverse reaction) to any medication or substance? .....Yes No  
If yes, please list: \_\_\_\_\_
2. Referring physician \_\_\_\_\_ Family physician \_\_\_\_\_
3. Occupation \_\_\_\_\_
4. What problem are you being treated for today? \_\_\_\_\_  
\_\_\_\_\_
5. Date of onset/problem/injury? \_\_\_\_\_
6. If this was an accident state how, when and where accident occurred? \_\_\_\_\_
7. Were you injured at work? .....Yes No
8. Have you seen another physician for your problem? .....Yes No  
Name of physician: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
9. Have you received or tried medication for your problem? .....Yes No  
Name of medication: \_\_\_\_\_
10. Have you had a cortisone injection for this problem? .....Yes No  
If so, how many? \_\_\_\_\_
11. Have you had physical therapy for this problem? .....Yes No  
If so, how many weeks: \_\_\_\_\_
12. Have you had X-Rays of the injured area? .....Yes No  
Date of X-Ray: \_\_\_\_\_ Where taken: \_\_\_\_\_
13. Do you have night pain? .....Yes No
14. Have you been under the care of a medical doctor during the past two years? .....Yes No  
If yes, for what? \_\_\_\_\_  
Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
15. Have you taken any medication or drugs during the past two years? .....Yes No
16. Are you taking any medication, drugs or pills now? .....Yes No  
If yes, please list name and dosage \_\_\_\_\_
17. Have you been a patient in the hospital during the past five years? .....Yes No
18. Previous surgeries, please list \_\_\_\_\_  
\_\_\_\_\_
19. Smoker? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ How much? \_\_\_\_\_
20. Use alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ How much? \_\_\_\_\_
21. Substance abuse? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ How much? \_\_\_\_\_
22. Height \_\_\_\_\_ Weight \_\_\_\_\_

23. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack).....	Yes	No	Ulcers .....	Yes	No	Hepatitis A (infectious) B (serum).....	Yes	No
Chest Pain .....	Yes	No	Diabetes .....	Yes	No	Venereal Disease .....	Yes	No
Congenital Heart Disease .....	Yes	No	Thyroid Problems .....	Yes	No	A.I.D.S. ....	Yes	No
Heart Murmur .....	Yes	No	Glaucoma .....	Yes	No	H.I.V. Positive.....	Yes	No
High Blood Pressure .....	Yes	No	Contact lenses.....	Yes	No	Cold Sores/Fever Blisters .....	Yes	No
Mitral Valve Prolapse .....	Yes	No	Emphysema.....	Yes	No	Blood Transfusion .....	Yes	No
Artificial Heart Valve .....	Yes	No	Chronic Cough .....	Yes	No	Hemophilia .....	Yes	No
Heart Pacemaker.....	Yes	No	Tuberculosis.....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever .....	Yes	No	Asthma .....	Yes	No	Bruise Easily.....	Yes	No
Arthritis/Rheumatism.....	Yes	No	Hay Fever .....	Yes	No	Liver Disease.....	Yes	No
Cortisone Medicine.....	Yes	No	Latex Sensitivity.....	Yes	No	Yellow Jaundice .....	Yes	No
Swollen Ankles .....	Yes	No	Allergies or Hives.....	Yes	No	Neurological Disorders .....	Yes	No
Stroke .....	Yes	No	Sinus Trouble .....	Yes	No	Epilepsy or Seizures.....	Yes	No
Diet (Special/Restricted).....	Yes	No	Radiation Therapy .....	Yes	No	Fainting or Dizzy Spells .....	Yes	No
Artificial Joints (hip, knee, etc.).....	Yes	No	Chemotherapy .....	Yes	No	Nervous/Anxious .....	Yes	No
Kidney Trouble .....	Yes	No	Tumors.....	Yes	No	Psychiatric/Psychological Care .....	Yes	No

24. Do you use more than two pillows to sleep?..... Yes No

25. Have you lost or gained more than 10 pounds in the past year?..... Yes No

26. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No

If yes, please list: \_\_\_\_\_

27. Women. Are you: Pregnant? Yes, \_\_\_ Months No Nursing? Yes No Taking birth control pills? Yes No

28. Pertinent family medical history (mother, father or siblings) \_\_\_\_\_

*I understand the above information is necessary to provide me with medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.*

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**History Review**

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_