

Today's Date: _____

Last IBJI Visit Date: _____

MEDICAL HISTORY FORM

PATIENT INFORMATION

Name (First) _____ (Last) _____ (Middle) _____

Age: _____ Date of Birth _____ Sex: M F

Height: _____ Weight: _____ lbs Rt or Lt Handed

Occupation _____

Working now? yes no retired disabled

PREFERRED PHARMACY

Pharmacy: _____

Address: _____

Phone: _____

HISTORY OF PRESENT ILLNESS

Reason for today's visit: _____

REFERRING PHYSICIAN

Name _____

Street _____ Suite _____

City _____ State _____ Zip Code _____

Phone _____

PRIMARY CARE PHYSICIAN (if different than above)

Name: _____

Address: _____

Phone: _____

* If your visit is related to an injury, circle the appropriate response in the box below. If it is not related to an injury, skip this box.

The injury is due to: car accident / work injury / sports injury / fall / other _____

The injury occurred at: home / work / school / other _____

Are you off work due to the injury? yes / no If yes, last day worked _____ If no, any restrictions _____

Is legal action / litigation pending due to this injury? yes / no

DATE of onset / injury _____ / _____ / _____ SYMPTOMS _____

LOCATION of symptoms: _____ right left both NA

Circle each characteristic that best describes your problem:

QUALITY: Sharp / Dull / Throbbing / Aching / Burning / Cramping

SEVERITY: Mild / Moderate / Severe

DURATION: Infrequent / Intermittent / Constant / Hourly / Daily / Weekly

TIMING: During Activity / After Activity / Walking / Running / Stairs / Squatting / Pivoting / Overhead use / Throw / Lift / Other

CONTEXT: Improving / Worsening / Recurrent / More Frequent / Less Frequent / Unchanged

SYMPTOM RELIEF: Rest / Heat / Cold / Elevation / Physical Therapy / Brace / Injection / Medication / Other: _____

SYMPTOM AGGRAVATION: Activity / Position Change / Repetitive Motion / Fatigue / Other: _____

ASSOCIATED SYMPTOMS: _____

TREATMENT Describe treatment and response for current problem _____

Have you had a problem with this area before? yes no If yes, describe problem and prior treatment: _____

Have you had any diagnostic tests for this problem? yes no If yes, what and where? _____

Do you have a copy of the test results? yes no Did you bring them with you? yes no

Has a physician recommended that you have surgery for this problem? yes no

Name of previous treating physician(s), if any: _____

PAST SURGICAL HISTORY:

Procedure: _____ Surgeon _____ Date _____

Procedure: _____ Surgeon _____ Date _____

Procedure: _____ Surgeon _____ Date _____

Procedure: _____ Surgeon _____ Date _____

SURGICAL COMPLICATIONS: _____

ANESTHESIA: Have you ever had **problems with anesthesia**? yes no If yes, please describe: _____

SLEEP APNEA: Do you have Sleep Apnea? yes no Snore? yes no Stop breathing during sleep? yes no

MEDICATIONS (Prescription / Nonprescription / Herbal supplements / Vitamins / Other):			
Medication	Dosage	How Long?	Side Effects

ALLERGIES: Please list type of allergy (medications, latex, food, metals, etc.) and type of reaction you experience: _____

SOCIAL HISTORY:

Student yes no School _____ Grade _____ Sport _____

Tobacco use: yes no Packs per day: _____ Pipe? yes no Smokeless Tobacco? yes no
 Quit Years Smoked: _____

Alcohol use: never occasional daily heavy History of alcoholism? yes no History of drug use? yes no

Marital status: single married divorced widowed

Do you live alone? yes no If no, who do you live with? _____

Are you pregnant? yes no Breastfeeding? yes no Date of last menstrual period: _____

Comments or Clarification: _____

Patient/Guardian Statement:

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

_____/_____/_____
 Patient Signature Date

_____/_____/_____
 Guardian Signature Date

 Guardian/Authorized Representative Printed 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

yes no _____/_____/_____
 Signed Date

yes no _____/_____/_____
 Signed Date