ILLINOIS BONE & JOINT INSTITUTE®
Move better. Live better.

Northwest Orthopaedics & Sports Medicine

Patient Demographics & Medical History

Date	Provider			Referred by
First Name	Middle Initial	Last Name		Email address
Street Address				Unit/Apt #
City		State		Zip Code
Home Number		Cell Number		Work Number
Social Security Number	Age	Birthdate	Marital Status M S D W	☐ Male ☐ Female ☐ _____
Primary Care Physician		Phone Number	Primary Preferred Language	
Name of Responsible Party		Address (if different than patient)		Will you need a translator? ☐ Yes ☐ No
Name of relative/friend (in case we are unable to reach you)			Relation	Phone Number
Pharmacy		Address		Phone Number

History of Present Illness:

Date of injury or onset: _____

Reason for today's visit: _____

Problem due to: ☐Car Accident ☐Work ☐Sports Injury ☐Fall ☐Arthritis ☐Other: _____

If injured, where did injury occur: ☐ Home ☐Work ☐School ☐Other: _____

Last day of work or school (if applicable) _____

Complete the section below only if your injury is work or automobile related		
Workmen's Comp / Auto Insurance Claim #		
Company Name	Contact Name	
Address	Phone Number	Fax Number
Employer Name		
Employer Address	Employer Phone Number	

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Agreement to Receive Electronic Communications

1. Name: _____ _____
   First Name *Last Name*

2. Date of Birth: _____
   MM *DD* *YY*

3. Contact Information:

   My Email: _____ My Phone: _____

4. Most Preferred Method of Communication:

   ☐ MyChart* ☐ Text Message ☐ Email

   ** MyChart allows you to send messages to your doctor, view your test results, schedule appointments, and more! A link will be sent to the email provided below.*

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing *Northwest Orthopaedics & Sports Medicine* any updates to my email address and/or mobile phone number.

I can withdraw my consent to electronic communications by calling / emailing:
(773) 631-7898 / NOSMINFO@IBJI.COM

Signature: _____ Date: _____

Last Name _____ First Name _____

Dominance ☐ Right-Handed ☐ Left-Handed Height _____ Weight _____

Location of pain: _____ If the problem is limb related is it the: ☐ Right ☐ Left ☐ Both

Have you fallen within the past year? ☐ Yes ☐ No Did this result in an injury? ☐ Yes ☐ No

Indicate the characteristics that describe your problem (*circle one or more*)

Pain	**Onset**	**Frequency**	**Context**	
Sharp	Sudden	Intermittent	Standing	Sitting
Dull	Slowly	Constant	Kneeling	Lying down
Throbbing	**Severity**	**Timing**	Down stairs	Up stairs
Aching	Minor	AM or PM	Walking	Running
Burning	Moderate	While Sleeping	Coughing	Lifting
Other	Severe	After Activity	Straining w/ a bowel movement	
		During Activity		

Associated Symptoms (*circle one or more*)

Do you notice any sensation listed below that occurs due to injury or at the site?

Weakness	Stiffness	Locking	Popping
Visible Swelling	Discoloration	Numbness	Tingling
Fever	Crunching	Chills	Discharge/Blood at Site

Other _____

On a scale from 1-10 please rate your pain with 1 being barely noticeable: _____

What makes the pain worse? _____

Is this the first time you have had a problem with this area? ☐ Yes ☐ No

Describe prior problem: _____

For this problem, have you had any of these tests done?

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Ultrasound ☐ Bone Scan ☐ EMG ☐ Nerve Study

If yes, where? _____ Did you bring them? ☐ Yes ☐ No

Allergies

☐ None	☐ Iodine	☐ Shellfish	☐ Sulfa
☐ Penicillin	☐ Lidocaine	☐ Food _____	☐ Other _____
☐ Local Anesthetic	☐ Contrast	☐ Metal/Jewelry	
☐ Codeine	☐ Latex	☐ Aspirin	

Level of Education: ☐ 0-12 ☐ Some College ☐ College Grad ☐ Professional ☐ Other _____

Past Surgical History:

Type of Surgery_____Year _____ Type of Surgery_____Year _____

Type of Surgery_____Year _____ Type of Surgery_____Year _____

Type of Surgery_____Year _____ Type of Surgery_____Year _____

Last Name _____ First Name _____

Past Medical History

Have you or any family member had any of the following medical problems?

You	Family	You	Family	You	Family
☐	☐ No Past Medical History	☐	☐ Dementia	☐	☐ Obesity
☐	☐ Anemia	☐	☐ Depression	☐	☐ Osteoarthritis
☐	☐ Anesthesia Problems	☐	☐ Diabetes Type I	☐	☐ Osteoporosis
☐	☐ Anxiety	☐	☐ Diabetes Type II	☐	☐ Pacemaker/Defibrillator
☐	☐ Atrial Fibrillation/Irregular Heartbeat	☐	☐ Emphysema	☐	☐ Parkinson's
☐	☐ Bleeding Disorder	☐	☐ Endocrine Disorders	☐	☐ Phlebitis
☐	☐ Blood Clots/Pulmonary Embolism	☐	☐ Hepatitis	☐	☐ Reflux
☐	☐ Cancer	☐	☐ High Blood Pressure	☐	☐ Rheumatoid Arthritis
☐	☐ Colitis	☐	☐ High Cholesterol	☐	☐ Stroke
☐	☐ Congestive Heart Failure	☐	☐ HIV/AIDS	☐	☐ Tuberculosis
☐	☐ COPD	☐	☐ Kidney Stones	☐	☐ Other: _____

Family Medical History: If your parents, grandparents, siblings, or children have any of the medical problems listed above, please explain: _____

_____

Occupation _____ Working Now? ☐ Yes ☐ No

Do you use tobacco? ☐ No ☐ Yes – packs/day_____ If you quit, how long ago? _____

Alcohol Use: ☐ No ☐ Yes ☐ Rarely ☐ Occasionally ☐ Daily ☐ Heavy

Drug Use: ☐ No ☐ Yes ☐ Rarely ☐ Occasionally ☐ Daily ☐ Heavy

History of Alcoholism? ☐ No ☐ Yes History of Recreational Drug Use? ☐ No ☐ Yes

Do You Live Alone? ☐ No ☐ Yes If no, who do you live with? _____

Type(s) of Exercise/Sports Activity: _____

How Often Per Week? _____

Review of Systems:

*Are you **CURRENTLY** having problems with the following?*

Genitourinary
☐ Blood in urine
☐ Kidney Stones
☐ Testicle Pain

Constitutional
☐ Fatigue
☐ Fever
☐ Weight Change

Respiratory
☐ Short of Breath
☐ Cough
☐ Bronchitis

Endocrine
☐ Excessive Urination
☐ Hormone/Metabolic Disorder
☐ Thyroid Disease

Skin
☐ Rash/Itching
☐ Dry Skin
☐ Non-Healing Sores
☐ Temperature Sensitivity

Gastrointestinal
☐ Nausea
☐ Rectal Bleeding
☐ Constipation
☐ Diarrhea

Neurological
☐ Headaches
☐ Tremors
☐ Seizures
☐ Neuropathy

Ears/Nose/Mouth
☐ Hearing Loss/Ringing
☐ Sinus Problem
☐ Sore Throat
☐ Nose Bleeds

Psychiatric
☐ Insomnia
☐ Confusion
☐ Depression

Eyes
☐ Glasses/Contacts
☐ Glaucoma
☐ Blurred Vision
☐ Eye Disease

Musculoskeletal
☐ Pain/Cramps
☐ Joint/Pain
☐ Joint Swelling
☐ Trouble Walking

Hematologic
☐ Bruise Easily
☐ Slow to Heal
☐ Enlarged Glands

Cardiovascular
☐ Cardiac Disorder
☐ Palpitations
☐ Swollen Ankles

Other
☐ _____
☐ _____
☐ _____

Last Name First Name

Please list all your current medications, including vitamins or supplements

Medication	Dosage	Frequency	Administration
			☐ Oral ☐ Injected ☐ Inhaled ☐ Intranasal ☐ Other:
			☐ Oral ☐ Injected ☐ Inhaled ☐ Intranasal ☐ Other:
			☐ Oral ☐ Injected ☐ Inhaled ☐ Intranasal ☐ Other:
			☐ Oral ☐ Injected ☐ Inhaled ☐ Intranasal ☐ Other:
			☐ Oral ☐ Injected ☐ Inhaled ☐ Intranasal ☐ Other:
			☐ Oral ☐ Injected ☐ Inhaled ☐ Intranasal ☐ Other:
			☐ Oral ☐ Injected ☐ Inhaled ☐ Intranasal ☐ Other:
			☐ Oral ☐ Injected ☐ Inhaled ☐ Intranasal ☐ Other:
			☐ Oral ☐ Injected ☐ Inhaled ☐ Intranasal ☐ Other:

Patient/Guardian Statement:
To the best of my knowledge, the above information is accurate and complete.

Patient/Guardian Signature *Date*

If patient is unable to sign:

First Name and Last Name of Authorized Representative

Signature of Authorized Representative *Date*