Patient Name: _____
MR#: _____
Today's Date: _____

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

PERSONAL HISTORY FORM

Referring Physician: _____ **City:** _____ **Phone:** _____
Primary Care Physician: _____ **City:** _____ **Phone:** _____
Pharmacy: _____ **Addr:** _____ **Phone:** _____

Patient height: _____ **Patient weight:** _____

Do you have allergies? □ Yes □ No If yes, please list allergies & describe reaction: _____

Are you off work due to an injury? □ Yes □ No
If yes, last day worked: _____ If no, any restrictions: _____

If your visit is related to an injury, check off the appropriate response below:

The injury is due to: □ Car accident □ Work injury □ Sports injury □ Fall □ Other

The injury occurred at: □ Home □ Work □ School □ Other

Is legal action/litigation pending due to this injury? □ Yes □ No
Date of Injury/Onset: _____ Symptoms: _____
Location of symptoms: _____ □ RT □ LT □ Both □ N/A

If it is not related to an injury, please fill out the reason for your visit here: _____

Do you have a history of previous fractures? □ Yes □ No _____

Circle each & every characteristic that BEST describes your problem:

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

Severity: Please rate on a scale of 1-10 with 10 being the worst _____

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

Timing: During activity / After activity / Walking / Running / Stairs / Squatting / Pivoting
Overhead use / Throwing / Lifting / 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 / Repetition motion / Fatigue / Other: _____

Associated Symptoms: _____

Have you had any of the following services this year (Circle all that apply):

Physical Therapy / Occupational Therapy / Chiropractic Services / Home Health Services

MEDICATION HISTORY - Please include prescription drugs and drugs you buy over the counter:

	Medication	Dose/Strength	When do you take it?	Reason you take it:
1.				
2.				
3.				
4.				
5.				
6.				
7.				

FAMILY MEDICAL HISTORY:

Condition	Self	Father	Mother	Sibling	Child	Grandparent
Alzheimer's						
Anemia						
Anxiety						
Asthma						
Bladder Control Problems						
Bladder Infections						
Bleeding Tendency						
Blood Clot (DVT)						
Cancer						
Coagulation Disorder						
COPD						
Depression						
Diabetes type 1						
Diabetes type 2						
Diverticulitis						
Emphysema						
Esophageal Reflux (GERD)						
Glaucoma						
Gout						
Heart Attack (Myocardial Infarction)						
Heart Disease						
Heart Palpitations						
Hepatitis A						
Hepatitis B						

Condition	Self	Father	Mother	Sibling	Child	Grandparent
Hepatitis C						
High Blood Pressure						
High Cholesterol						
History Of Fractures (specify fx)						
HIV						
Hyperthyroidism						
Hypothyroidism						
Kidney Disease						
Kidney Stones						
Liver Disease						
Lung Disease						
Lupus Erythematosus						
Lyme Disease						
Malignant Hyperthermia						
Migraine Headache						
Multiple Sclerosis						
None						
Osteoarthritis						
Osteomyelitis						
Osteopenia						
Osteoporosis						
Other						
Parkinson's Disease						
Pneumonia						
Psoriasis						
Pulmonary Embolism						
Rheumatoid Arthritis						
Sciatica						
Seizures						
Shingles						
Sleep Apnea						
Sleep Disorder						
Steroid Use						
Stomach Ulcers						

Condition	Self	Father	Mother	Sibling	Child	Grandparent
Stroke/TIA						
Thyroid Disease						
Tuberculosis						
Varicose Veins						

PAST SURGICAL/HOSPITALIZATION HISTORY:

Procedure	Surgeon	Date:

CURRENT SOCIAL HISTORY - Circle one for each that apply below:

Tobacco use: Every day smoker / Occasional smoker / Heavy smoker / Never smoked / Former smoker

Year started smoking: _____ Year quit: _____

Alcohol use: How many drinks per week? _____ History of alcoholism? □ Yes □ No

Do you live alone? □ Yes □ No If no, who do you live with? _____

Have you received any of the following immunizations? If yes, please list the date it was last received:

Influenza/Flu: _____ Pneumovax: _____ COVID-19: _____

For females:

Menstruation age? _____ Menopause age? _____

History of miscarriage? □ Yes □ No History of parental hip fracture? □ Yes □ No

Are you currently pregnant? □ Yes □ No

For male and females aged 65+

Have you had 2 or more falls in the past year or any fall with injury in the past year? □ Yes □ No

Date of last dexa scan: _____

If you are permanently or temporarily residing in a skilled medical nursing/long-term facility/nursing home or rehabilitation center, please complete below:

Facility name: _____ City: _____ Date: _____

Patient's Name: _____

Patient's Signature: _____ Date: _____