Name:
Chart:
Date:

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

Medical History Update

Date of Birth:_____ Current Height:_____ Current Weight:_____

Have there been any **changes in your medical history** since your last visit? If yes, please describe:

_____

_____

Do you have any **allergies** not listed on the previous history? If yes, please describe:

_____

Are you taking or have you regularly taken any **medicine** not listed on the previous history? If yes, please describe:

_____

Are there any other **changes in your health** that we should know about? If yes, please describe:

_____

PLEASE COMPLETE FOR NEW CONDITIONS OR PROBLEMS

Reason for today's visit: _____

* If your visit is related to an injury, check 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

Check each characteristic that best describes your problem:

QUALITY:
Sharp ☐
Throbbing ☐
Aching ☐
Burning ☐
Cramping ☐

SEVERITY:
Mild ☐
Moderate ☐
Severe ☐

DURATION:
Infrequent ☐ Daily ☐
Constant ☐ Weekly ☐
Hourly ☐

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

CONTEXT:
Worsening ☐ Less Frequent ☐
Recurrent ☐ Unchanged ☐
More Frequent ☐

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

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

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 surgery? yes ☐ no ☐ Name of previous treating physician(s), if any: _____

Patient or Guardian: _____ _____
Signature Date

Parent/Guardian, if applicable: _____ _____
Print name Relationship

IBJI Physician: _____ _____
Signature Date