Bellevue Bone and Joint Physicians

Patient Medical History

Name ____Date of Birth____________ Male☐ Female☐

Occupation ______________________________Referring Physician______________________________

Primary Care Physician ____

PRESENT COMPLAINT: (describe condition or symptoms for which you are being seen for today)

____

Indicate Body area: ____ Left☐ Right☐ Both☐

Details of injury or onset____

Severity of pain (Please Circle) 1 2 3 4 5 6 7 8 9 10

☐Sharp ☐Dull ☐Throbbing ☐Stabbing ☐Numbness ☐Radiating ☐Bruising

☐Tingling ☐Locking ☐Swelling ☐Constant ☐Intermittent ☐AM ☐PM

Date of Injury__________________ If not injury, give: Date of onset ______________________________

Was injury related to: Work ☐ Auto ☐ Right Hand☐ Left Hand☐ Dominant

What makes the symptoms worse☐ better☐ ____

Any Previous Treatment for this Problem? Explain ____

List any allergies to medication, metal, eggs, chicken or feathers ___________________________________

List any Medication you are currently taking and what it is for_____________________________________

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____

REVIEW OF SYMPTOMS: Check boxes next to all symptoms that you currently have

☐Chest Pain	☐Blurred/Double Vision	☐Stent	☐Numbness/Tingling
☐Palpitations	☐Red Eyes	☐Incontinence	☐Poor Balance/Vertigo
☐Irregular Heart Beat	☐Headaches	☐Small Urine Stream	☐Dizziness
☐High Blood Pressure	☐Hearing Loss	☐Difficult/Painful Urination	☐Poor Healing
☐Weight Loss/Gain	☐Cough	☐Frequent Urination	☐Rash/Itching
☐Fever/Chills	☐Short of Breath	☐Joint Pain/Swelling	☐Recurrent Infections
☐Fatigue	☐Heart Burn	☐Unstable Joints	☐Bruise/Bleed Easily
☐Loss of appetite	☐Nausea	☐Stiff Joints	☐Pregnant
☐Eye Pain	☐Ulcers	☐Muscle Pain	☐Hearing Aids
☐Pre ☐Post Menopausal			

By Staff: Height	Weight	BP	Pulse	Temp

Patient Medical History Continued

SOCIAL HISTORY:

Do you smoke/use tobacco Products?
Yes ☐ No ☐ If Yes, how much? __________ packs per day for _______ years

Do you drink alcohol?
Yes ☐ No ☐ If Yes, how much? __________

Do you drink caffeine?
Yes☐ No☐ If Yes, how much? _______

What is your highest level of education?____

PAST MEDICAL HISTORY:

Condition	Explain	Condition	Explain
☐ AIDS/HIV/STD	___________________________	☐ Heart Attack/Angina	_______________________
☐ Alcoholism	_______________________________	☐ Kidney/Liver Disease/Hepatitis	_______________
☐ Anemia	__________________________________	☐ Number of Pregnancies	_____________________
☐ Arthritis (OA/RA)	_________________________	☐ Osteoporosis	_____________________________
☐ Bleeding Problems/Blood Clots	______________	☐ Pacemaker/Defibrillator	_____________________
☐ Cancer	__________________________________	☐ Prostate Problem	__________________________
☐ Depression	______________________________	☐ Psychiatric Treatment	_______________________
☐ Diabetes (Juvenile/Adult Onset)	_____________	☐ Stroke/MS	_______________________________
☐ Emphysema	_____________________________	☐ Thyroid Disorders	_________________________
☐ Fibromyalgia	____________________________	☐ Ulcers/GERD	_____________________________
☐Fractures	________________________________	☐ Vitamin D Deficiency	______________________
☐ Glaucoma	_______________________________		

PAST SURGICAL HISTORY: Please list all previous surgeries. None ☐

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FAMILY HISTORY: Is there a family history of:

			Mother	Father	Sibling
Heart Disease	YES ☐	NO ☐	__________	__________	__________
Stroke	YES ☐	NO ☐	___________	__________	__________
Diabetes	YES ☐	NO ☐	___________	__________	__________
Cancer	YES ☐	NO ☐	___________	___________	__________
Arthritis	YES ☐	NO ☐	___________	___________	__________

Signature ____ Date ________________________