

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, eggs, chicken or feathers _____

List any Medication you are currently taking and what it is for _____

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

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

Bv Staff: Height	Weight	BP	Pulse	Temp
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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: Check all boxes that apply to you?

Y	N	Explain	Y	N	Explain
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV/STD _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Angina _____
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver Disease/Hepatitis _____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia _____	<input type="checkbox"/>	<input type="checkbox"/>	Number of Pregnancies _____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (OA/RA) _____	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis _____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems/Blood Clots _____	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/Defibrillator _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problem _____
<input type="checkbox"/>	<input type="checkbox"/>	Depression _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Treatment _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Juvenile/Adult Onset) _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/MS _____
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorders _____
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia _____	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/GERD _____
<input type="checkbox"/>	<input type="checkbox"/>	Fractures _____	<input type="checkbox"/>	<input type="checkbox"/>	Vitamin D Deficiency _____
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____			

PAST SURGICAL HISTORY: Please list all previous surgeries. None

FAMILY HISTORY: Is there a family history of:

		Mother	Father	Sibling
Heart Disease	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____	_____
Stroke	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____	_____
Diabetes	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____	_____
Cancer	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____	_____
Arthritis	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	_____	_____

Signature _____ Date _____