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Name:	/ MR#	

	Today's Date:				
MEDICAL HISTORY FORM	Last IBJI Visit Date: REFERRING PHYSICIAN				
PATIENT INFORMATION					
Name (First) (Last) (Middle)	Name				
Age: Date of Birth Sex: ☐ M ☐ F	Street	Suite			
Height: lbs □ Rt or □ Lt Handed		57			
Occupation	City	State Zip Code			
Working now? ☐ yes ☐ no ☐ disabled ☐ retired If retired, what	Phone twas your previous occupation:				
PREFERRED PHARMACY	PRIMARY CARE PHYSICIAN				
		Min Minaria Watten naren-eraila			
Pharmacy:		·			
Address:	Address:				
Phone:	Phone:				
HISTORY OF PRESENT ILLNESS Reason for today's visit:					
* If your visit is related to an injury, circle the appropriate res	sponse in the box below. If it is not r	elated to an injury, skip this box.			
The injury is due to: car accident / work injury / sports in	jury / 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 res	strictions			
Is legal action / litigation pending due to this injury? yes /	no				
DATE of onset / injury / SYMPTOM	MS				
	12 2039				
Circle each characteristic that best describes your problem:					
QUALITY: Sharp / Dull / Throbbing / Aching / Burning	/ Cramping				
SEVERITY: Mild / Moderate / Severe					
DURATION: Infrequent / Intermittent / Constant / Hourly / D	aily / Weekly				
TIMING: During Activity / After Activity / Walking / Running	/ Stairs / Squatting / Pivoting / Ove	rhead use / Throw / Lift / Other			
CONTEXT: Improving / Worsening / Recurrent / More Frequency	uent / Less Frequent / Unchanged				
SYMPTOM RELIEF: Rest / Heat / Cold / Elevation / Physic	President users user to see them.	ication / Other:			
SYMPTOM AGGRAVATION: Activity / Position Change / F	AND THE SAME OF STREET AND ARROWS				
AGGGGIATED COMPTONS	The second section of the second section of the second second second second second second second second second				
TREATMENT Describe treatment and response for current					
TREATMENT Describe treatment and response for current					
Have you had a problem with this area before? ☐ yes ☐ no		or 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 that you have surgery for the	is problem? ☐ yes ☐ no				
Name of previous treating physician(s), if any:					
Have you had any of the following services this year (check	all that apply):				
Physical Therapy Occupational Therapy	11-1	Home Health Services □			



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REVIEW of SYSTEMS:

Have you ever experienced or do you currently have any of the following signs or symptoms? If "Yes", please describe:

SYMPTOMS	Yes	No	Describe all "Yes" responses
Eyes (e.g. blurred vision, double vision, loss of vision)			
Ears, Nose, Throat (e.g. sore throat, earache, ringing)			
Cardiovascular (e.g. chest pain, palpitations, ankle swelling)			
Respiratory (e.g. shortness of breath, cough, snore)			
Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)			
Genitourinary (e.g. burning, bleeding or difficulty urinating)			
Musculoskeletal (e.g. joint, muscle, back or neck pain)			
Skin (e.g. delayed healing, rash, acne, cellulitis, psoriasis)			
Neurological (e.g. numbness, tingling, weakness)			
Mental Health (e.g. depression, anxiety, memory loss)			
Endocrine (e.g. weight gain/loss, excess thirst or urination)			
Hematologic (e.g. bruising, bleeding or clotting disorder)			
Allergic / Immunologic (e.g. rash, swelling, wheezing)			

PAST MEDICAL and FAMILY HISTORY:

Have you or a family member had problems with any of the following? Please indicate "Yes" with an "x".

DISEASE (CONDITION)	Self	Father Moth	er Sibling	Child	Grand parent	DISEASE/CONDITION	Sef	Father Mothe	r Sibiling	Child	Grand parent
Abnormal Heart Rhyshm						Hepatita					
AID3						High Blood Pressure					
Anemia						High Cholestero					
Angina						HIV					
Arthritis						Kidney Failure					
Asthma						Kidney Stones					
Bleeding Disorder						Liver Problem					
BFH (bengn prostation your pass)						Mental Disorder					
Cancer						MI myocatia naraon					
Cardiomyopathy						Osteoporosis					
Clotting Disorder						Psoriasis					
Colts						Psychiatric Problem					
COPO						Seizures					
Diabetes Mellitus						Slokle Cell Anemia					
Eozema						Stroke					
Emphysema						Thyroid					
Endocrine Frotiem						TIA itorgentischem: ataki					
Gall Bladder Disease						Tuberoulosis					
GERO						Ulcer.					
Heart Valve Problem	3					Urinary Tract Infection					
						Other					



Name:	/MR#	
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Surgeon Date	PAST SURGICAL I	HISTORY:		
Surgeon Date	Procedure:		Surgeon	Date
SURGICAL COMPLICATIONS: ANESTHESIA: Have you ever had a blood transfusion?	Procedure:		Surgeon	Date
ANESTHESIA: Have you ever had a blood transfusion? yes no If yes, please describe:	Procedure:		Surgeon	Date
ANESTHESIA: Have you ever had problems with anesthesia? yes no If yes, please describe:	SURGICAL COMP	LICATIONS:		
SLEEP APNEA: Do you have Sleep Apnea? yes no Snore? yes no Stop breathing during sleep? yes no FOR MALE AND FEMALES AGED 65+:		anababah 11 14	sthesia? ☐ yes ☐ no If yes, pl	ease describe:
SLEEP APNEA: Do you have Sleep Apnea? yes no Snore? yes no Stop breathing during sleep? yes no FOR MALE AND FEMALES AGED 65+:	BLOOD: Have you	ever had a blood transfusion? □ve	s □no Do you have a history	of blood clotting? □yes □no
Are you had 2 or more falls in the past year or any fall with injury in the past year? yes no	District Control of the Control of t	The transfer of the control of the c	Service Control of the Control of th	CONTRACTOR OF THE STATE OF THE
Are you currently taking a Vitamin D supplement? yes no Have you had a Dexa/Bone Density Study done in the past 5 years? yes no	FOR MALE AND F	EMALES AGED 65+:		
Have you had a Dexa/Bone Density Study done in the past 5 years? yes no	Have you had 2 or i	more falls in the past year or any fall	with injury in the past year?	□yes □no
If yes, were you told you have osteoporosis? gyes no	Are you currently ta	king a Vitamin D supplement?		□yes □no
If yes, are you taking prescription medication for osteoporosis? gyes no	Have you had a De	xa/Bone Density Study done in the p	past 5 years?	□yes □no
MEDICATIONS (Prescription / Nonprescription / Herbal supplements / Vitamins / Other): Medication Dosage Frequency Route of Administration ALLERGIES: Please list type of allergy (medications, latex, food, metals, etc.) and type of reaction you experience: SOCIAL HISTORY: Student yes no School	If yes, wer	e you told you have osteoporosis?	□yes	s⊡no
ALLERGIES: Please list type of allergy (medications, latex, food, metals, etc.) and type of reaction you experience: SOCIAL HISTORY: Grade	If yes, are	you taking prescription medication for	or osteoporosis?	i □no
ALLERGIES: Please list type of allergy (medications, latex, food, metals, etc.) and type of reaction you experience: SOCIAL HISTORY: Grade	MEDICATIONS	(Prescription / Nonprescription / H		
Social History: Student yes no School Grade Sport	Medication	Dosage	Frequency	Route of Administration
Heavy tobacco smoker	Student □ yes □ n	o School		A COST DO STORE TO
Alcohol use: never occasional daily heavy History of alcoholism? yes no History of drug use? yes no Marital status; single married divorced widowed wi		THE CONTRACTOR AND SAME THE PROPERTY OF THE PR		FORTH PROPERTY AND ADMINISTRATION OF THE PERSON OF THE PER
Manital status: single married divorced wildowed Do you live alone? yes no If no, who do you live with? Are you residing in a skilled nursing facility (SNF) either temporarily or permanently? yes no Are you pregnant? yes no Breastfeeding? yes no Date of last menstrual period: Comments or Clarification: Patient/Guardian Statement: To the best of my knowledge, the above information is accurate and complete. Patient Signature Date Guardian Signature Date Guardian Signature Date Date Date Signed Date		SATE AND	A STATE OF THE STA	
Patient/Guardian Statement: For the best of my knowledge, the above information is accurate and complete. Patient Signature Date Date Date Date Date Date Signed Date	Alcohol use: never	r □ occasional □ daily □ heavy Hist	ory of alcoholism? ☐ yes ☐ no	History of drug use? ☐ yes ☐ no
Are you residing in a skilled nursing facility (SNF) either temporarily or permanently?				
Are you pregnant?	ACCOMMODITION OF THE PARTY	TO CHIPOTONIO PERSONATE INIUNI		
Patient/Guardian Statement: For the best of my knowledge, the above information is accurate and complete. Patient Signature Date July Guardian Signature Date Date Date Date Date	Are you residing in a s	skilled nursing facility (SNF) either tempo	rarily or permanently? yes no	o .
Patient/Guardian Statement: For the best of my knowledge, the above information is accurate and complete. Patient Signature Date July Guardian Signature Date Date Date Date	Are you pregnant?	yes □ no Breastfeeding? □ yes	☐ no Date of last menstrual per	iod:
To the best of my knowledge, the above information s accurate and complete.	Comments or Clar	ification:		
To the best of my knowledge, the above information s accurate and complete.				
Saccurate and complete. Any Changes	Patient/Guardian S	Statement:	Provider Statement:	
Patient Signature Date Signed Date Guardian Signature Date			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	onnaire with the patient.
Guardian Signature Date	Patient Signature	//		d Date
	n coonsiderate		Signer	
Suardian/Authorized Representative Printed Name		4.50405255		