

Name: _____ / MR# _____

Today's Date: _____

Last IJBI Visit Date: _____

MEDICAL HISTORY FORM

PATIENT INFORMATION

Name (First) _____ (Last) _____ (Middle) _____
 Age: _____ Date of Birth _____ Sex: M F
 Height: _____ Weight: _____ lbs Rt or Lt Handed
 Occupation _____

Working now? yes no disabled retired If retired, what was your previous occupation: _____

PREFERRED PHARMACY

Pharmacy: _____
 Address: _____
 Phone: _____

REFERRING PHYSICIAN

Name _____
 Street _____ Suite _____
 City _____ State _____ Zip Code _____
 Phone _____

PRIMARY CARE PHYSICIAN (if different than above)

Name: _____
 Address: _____
 Phone: _____

HISTORY OF PRESENT ILLNESS

Reason for today's visit: _____

* If your visit is related to an injury, circle 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

Circle each characteristic that best describes your problem:

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

SEVERITY: Mild / Moderate / Severe

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

TIMING: During Activity / After Activity / Walking / Running / Stairs / Squatting / Pivoting / Overhead use / Throw / Lift / 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 / Repetitive Motion / Fatigue / Other: _____

ASSOCIATED SYMPTOMS: _____

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 that you have surgery for this 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 Chiropractic Services Home Health Services

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PAST SURGICAL HISTORY:

Procedure: _____ Surgeon _____ Date _____
 Procedure: _____ Surgeon _____ Date _____
 Procedure: _____ Surgeon _____ Date _____

SURGICAL COMPLICATIONS: _____

ANESTHESIA: Have you ever had **problems with anesthesia**? yes no If yes, please describe: _____

BLOOD: Have you ever had a blood transfusion? yes no Do you have a history of blood clotting? yes no

SLEEP APNEA: Do you have Sleep Apnea? yes no Snore? yes no Stop breathing during sleep? 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

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

If yes, were you told you have osteoporosis? yes no

If yes, are you taking prescription medication for osteoporosis? 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 _____ Grade _____ Sport _____

Tobacco use: Check all those that apply: Current every day smoker Current some day smoker **Year started smoking** _____

Heavy tobacco smoker Light tobacco smoker

Never smoker Former smoker **Year Quit** _____

Alcohol use: never occasional daily heavy History of alcoholism? yes no History of drug use? yes no

Marital status: single married divorced widowed

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/Authorized Representative Printed Name

Provider Statement:

I have reviewed the questionnaire with the patient.

Any Changes

yes no

_____/_____/_____
Signed Date