River Cities Bone and Joint Centre

Medical History Form

Patient Name: _____ DOB: _____ Age: _____

Dominant Hand: ☐ R ☐ L Height: _____ Weight: _____

Gender ☐ Male ☐ Female

What body part is involved? (Please mark ONLY ONE on the table below)

Shoulder	Elbow	Wrist	Hand	Hip
☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ I	☐ R ☐ L
Knee	**Ankle**	**Foot**	**Neck**	**Back**
☐ R ☐ L	☐ R ☐ L	☐ R ☐ L	☐ R ☐ I	☐ R ☐ L

*What test/ scans have you had for this problem? ☐ X-Ray ☐ MRI ☐ CATscan ☐ Bone Scan

Where? _____ ☐ Nerve Test

In this section, check the ONE BOX that describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

☐ NO INJURY (or onset was) ☐ Gradual ☐ Sudden

How long ago did it start? ____ Days ____ Weeks ____ Months ____ Years

Please indicate why you think it started.

☐ INJURY ☐ Accident ☐ Sport (NOT Auto or Work)

Date: _____ Please specify where and how it happened.

What Sport? _____ School? _____

☐ INJURY AT WORK Date: _____

From a: ☐ Lift ☐ Twist ☐ Fall ☐ Bend ☐ Pull ☐ Reach

☐ WORK RELATED (BUT NO INJURY)

Date: _____ How did your job cause the problem?

☐ AUTO ACCIDENT

Date: How was your car hit?

Comments: _____

On a scale of 0-10 (10 is the worst) how severe is your pain? (Circle) 0 1 2 3 4 5 6 8 9 10

What is the quality of your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes and goes (intermittent).

Does your pain wake you from your sleep? ☐ Y ☐ N

Do you have: ☐ Swelling ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Locking/Catching ☐ Giving Away ☐ Loss of control of bowel or bladder

Since my problem started it is: ☐ Better ☐ Worse ☐ Unchanged

Which make your symptoms better? ☐ Rest ☐ Elevation ☐ Ice ☐ Other

Which makes your symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting ☐ Lying in bed ☐ Sitting ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sneezing ☐ Coughing

Were you seen in the E.R for this problem? ☐ Y ☐ N Which E.R? _____ Date: _____

Have you had any of these treatments? Injection: ☐ Y ☐ N Physical Therapy: ☐ Y ☐ N

Brace/Cast: ☐ Y ☐ N

Have you had a prior problem or surgery in this same area or issue either recently or in the past? Y ☐ N ☐

If so, please explain: Procedure: _____ Surgeon: _____

City: _____ Date: _____

Do your other joints have: ☐ Morning stiffness lasting over 30 minutes ☐ Joint pain or swelling

☐ Gout ☐ Back Pain ☐ Rheumatoid Arthritis ☐ Osteoporosis

☐ Prior Fracture (Which bone?) _____ ☐ None of these

Patient Medical History

Please check all that apply:

AIDS/HIV ☐	ALCHOLISM ☐	ANEMIA ☐	ASTHMA ☐
BLOD CLOTS ☐	COPD ☐	CROHN'S DISEASE ☐	DEPRESSION ☐
DRUG ABUSE ☐	FIBROMYALGIA ☐	GOUT ☐	HEART DISEASE ☐
HYPERTENSION ☐	KIDNEY DISEASE ☐	MIGRANE HEADACHES ☐	THYROID DISEASE ☐
OSTEOARTHRITIS ☐	PARKINSON DISEASE ☐	RHEUMATOID ARTHRITIS ☐	SEZURES ☐
ULCERS ☐	DIABETES ☐	CANCER ☐ (TYPE?) _____	

Medications

Allergies to Medications? Y ☐ N ☐

If so, please list allergies and describe reaction:

_____

_____

What medications are you taking now?

Medication Name:_____ Dosage:_____ Frequency: _____

Medication Name:_____ Dosage:_____ Frequency: _____

Medication Name:_____ Dosage:_____ Frequency: _____

Medication Name:_____ Dosage:_____ Frequency: _____

Medication Name:_____ Dosage:_____ Frequency: _____

Medication Name:_____ Dosage:_____ Frequency: _____

Medication Name:_____ Dosage:_____ Frequency: _____

Medication Name:_____ Dosage:_____ Frequency: _____

Past Medical History

Are you diabetic? Y ☐ N ☐ If so, treatment: ☐ Insulin ☐ Oral Medicine ☐ Diet

Are you taking or have you ever taken, blood thinners? Y ☐ N ☐ If so, which ones? _____

Have you ever had: ☐ Heart Attack (Year?) _____ ☐ High Blood Pressure

☐ Blood Clots (Year?) _____ ☐ Stroke ☐ Heart Failure

☐ Ankle Swelling ☐ Kidney Failure

Past Surgical History

What operations have you had and when? Please list:

_____

_____

_____

_____

_____

Family History

Have any direct relatives had any of the following disorders? If so which relative?

	Mother	Father		Mother	Father
AIDS/HIV	☐	☐	CANCER (TYPE:_____)	☐	☐
ALCOHOLISM	☐	☐	COPD	☐	☐
ALZHEIMER'S	☐	☐	CROHN'S DISEASE	☐	☐
ANEMIA	☐	☐	DEPRESSION	☐	☐
ASTHMA	☐	☐	DRUG ABUSE	☐	☐
BLOOD CLOTS	☐	☐	FIBROMYALGIA	☐	☐
GOUT	☐	☐	HEART DISEASE	☐	☐
HYPERTENSION	☐	☐	HEPATITIS	☐	☐
KIDNEY DISEASE	☐	☐	MIGRANE HEADACHES	☐	☐
OSTEOARTHRITIS	☐	☐	PARKINSON DISEASE	☐	☐
RHEUM. ARTHRITIS	☐	☐	SEIZURES	☐	☐
THYROID DISEASE	☐	☐	ULCERS	☐	☐
DIABETES	☐	☐	OTHER (_____)	☐	☐

Social History

Do you use tobacco? Y ☐ N ☐ If so, Type?: _____ How much?_____

Do you smoke? Y ☐ N ☐ If so, how many packs a day: _____

Do you use Alcohol? Y ☐ N ☐ If so, how often? ☐ Daily ☐ Other_____/week ☐ Social

Do you use caffeine? Y ☐ N ☐ If so, Type? _____

Current work status? ☐ Regular ☐ Light Duty

☐ Disabled ☐ Retired ☐ Student

☐ Not working due to this problem (When is the last date you worked your regular job?) _____

PLEASE SIGN: The information on this form is accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____