

# UTAH BONE & JOINT CENTER

## Patient Medical History Questionnaire

*PLEASE COMPLETE THIS FORM AS THOROUGHLY AS POSSIBLE PRIOR TO SEEING YOUR PHYSICIAN*

Record #: _____
Date: ____/____/____

Name: \_\_\_\_\_ Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ Date Of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Who is your Primary Care Doctor or Provider?: \_\_\_\_\_

**History:** Your Age: \_\_\_\_\_ **Dominant Hand:** Right/ Left **Sex:** M / F

**Chief Complaint/Reason for your visit today:** \_\_\_\_\_

Is this related to an injury? Explain: \_\_\_\_\_

**HISTORY OF THIS PROBLEM (Did you injure this at work?)**  YES  NO

Where does it hurt? \_\_\_\_\_ Type of pain/discomfort (e.g., achy, burning, sharp) \_\_\_\_\_

The pain is(circle one): mild; moderate; high; severe How long does it last? \_\_\_\_\_

When does it occur? \_\_\_\_\_ Any specific activity? \_\_\_\_\_

What makes it better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Associated symptoms (e.g., numbness, tingling, weakness, etc.)? Describe them: \_\_\_\_\_

**PAST MEDICAL/SURGICAL, FAMILY, & SOCIAL HISTORY**

*Be sure to complete these.*

**ALLERGIES:** Any medication allergies?:  YES  NO, If yes, list medication & reaction: \_\_\_\_\_  
 (CIRCLE WHAT APPLIES: itching, hives, shortness of breath, etc.)

LIST ALL CURRENT MEDICAL PROBLEMS & CONDITIONS	
1 _____	3 _____
2 _____	4 _____

LIST ALL PREVIOUS SURGERIES			
Year	Surgery	Year	Surgery

LIST ALL PREVIOUS HOSPITAL ADMISSIONS EXCEPT SURGERY			
Year	Hospitalized	Year	Hospitalized

LIST ALL CURRENT MEDICATIONS AND DOSES									
Medication	Dose	How	How	Medication	Dose	How	How		

**Any Family History of:** (circle all that apply; **Y = Yes, N = No**)

Deep Vein Clot: Y/N    Arthritis (RA/OA): Y/N    High Blood Pressure: Y/N    Heart Disease: Y/N  
 Lung Clot: Y/N    Low Thyroid: Y/N    Diabetes: Y/N    Muscular Disease: Y/N  
 Stroke: Y/N    Bleeding Problems: Y/N    Problems with Anesthesia: Y/N

Cancer of (circle all that apply):    Breast    Lung    Thyroid    Kidney    Prostate

**Social History:** Single / Married; Any children? Y/N; Their ages: \_\_\_\_\_; Live with spouse or partner? Y/N

Do you drink **alcohol** (Beer/Wine/Liquor)? Y/N -- If yes, how many drinks per week? \_\_\_\_\_

Do you use **tobacco**? Y/N - # \_\_\_\_\_ packs/day, # \_\_\_\_\_ years. QUIT? When? \_\_\_\_\_

**Current Employment** (describe what you do): \_\_\_\_\_

If **un**employed, how long? \_\_\_\_\_ Is **Legal Action** pending on your injury? \_\_\_\_\_

<b>This area for nurse:</b>
Height: _____
Weight: _____
Pulse: _____
Blood Pressure: _____

**\*\*\* Please Complete Reverse Side As Well \*\*\***

**MEDICAL SYSTEMS REVIEW**  
**Do you have a Past or Present History of:**  
(Please Mark an "X" Beside All Applicable Problems)

<u>EYES</u>	<u>Past / Present</u>	<u>HEART</u>	<u>Past / Present</u>	<u>BLOOD</u>	<u>Past / Present</u>
Cataracts	___ ___	Aching in Mid-Chest	___ ___	Anemia	___ ___
Double Vision	___ ___	Skipping Beats	___ ___	Very Easy Bruising	___ ___
Sudden Vision Loss	___ ___	Shortness of Breath	___ ___	Bleeding Disorder	___ ___
Glaucoma	___ ___	Fainting Spells	___ ___	Lumps Under Arms/ in Groin	___ ___
<u>EARS</u>		Heart Murmur	___ ___	<b>Deep vein or lung clots</b>	___ ___
Buzzing/Whistling	___ ___	Swelling of Ankles	___ ___	<u>ENDOCRINE</u>	
Spinning Dizziness	___ ___	High Blood Pressure	___ ___	Thyroid Trouble	___ ___
Loss of Hearing	___ ___	# of years _____	___ ___	Diabetes	___ ___
		<b>Heart Attack</b>	___ ___		
		How Many? _____			
		When? _____			
<u>NOSE &amp; THROAT</u>		<u>GASTROINTESTINAL</u>		<u>BREASTS</u>	
Pain	___ ___	Heart Burn	___ ___	Lump in Breast	___ ___
Bleeding	___ ___	Constipation	___ ___	Cancer	___ ___
Chronically Stuffy Nose	___ ___	Recent Change in Bowel Habits	___ ___	<u>ALLERGY/IMMUNOLOGIC</u>	
<u>MUSCULOSKELETAL</u>		Vomiting of Blood	___ ___	Eczema/Psoriasis/ Dermatitis (circle one)	___ ___
Morning Joint Stiffness	___ ___	Ulcers	___ ___	Allergy to Latex Rubber	___ ___
Swelling/Aching Joints	___ ___	Black, Tarry Stools	___ ___		
Severe Backaches	___ ___	Bright, Red Blood by Rectum	___ ___	<u>VIRAL ILLNESS EXPOSURE</u>	
<u>NERVOUS SYSTEM</u>		Swelling of Abdomen	___ ___	Hepatitis	___ ___
Seizures/Convulsions	___ ___	Jaundice	___ ___	Type A ___ B ___ C ___ Other ___	
Stroke	___ ___	Tea Colored Urine	___ ___	HIV Exposure	___ ___
Paralysis/Weakness of a Limb	___ ___	<u>URINARY</u>		HIV Infection	___ ___
Increasing Trouble w/ Memory	___ ___	Burning on Urination	___ ___	"AIDS"	___ ___
Tingling or Numbness in a Limb	___ ___	Bloody Urine	___ ___	<u>PSYCHIATRIC</u>	
Staggering	___ ___	Frequent Urination	___ ___	Depression	___ ___
Migraine Headache	___ ___	Difficulty in Getting Urination Started	___ ___	Anxiety Attacks	___ ___
		Backaches	___ ___		
<u>CHEST</u>		Losing Urine Control w/ Coughing/Sneezing	___ ___	<u>ANY OTHER MEDICAL PROBLEMS WE SHOULD KNOW ABOUT?</u>	
Coughing up Blood	___ ___	Kidney Stone	___ ___	_____	
Pneumonia	___ ___	<u>HEAD AND NECK</u>		_____	
<b>Blood Clots</b> to Lungs	___ ___	Stiff Neck	___ ___	_____	
Tuberculosis	___ ___	Severe or Frequent Headaches	___ ___	_____	
Wheezing or Asthma	___ ___	<u>SKIN</u>		_____	
		Hives	___ ___	_____	
		Shingles	___ ___	_____	
		Recurrent Itching	___ ___	_____	
		Ulcers	___ ___	_____	

**PLEASE SIGN AND DATE AFTER  
COMPLETING THIS CHECKLIST:**



Patient Signature: _____	Date: _____	<b>***THIS INFORMATION WILL BE REVIEWED &amp;  UPDATED DURING YOUR FUTURE VISITS  TO OUR CLINIC. ***</b>
Patient Signature: _____	Date: _____	
Patient Signature: _____	Date: _____	