

Alpine Bone & Joint Clinic

Medical History Questionnaire

Name: _____ Age: _____ Date: _____

Briefly describe your present illness / injury (Include date of injury, treatment received / surgery, if any): _____

Did this injury occur at work? No Yes, Employer _____

What physical restrictions have you experienced because of this problem? _____

Have you previously seen another medical doctor for this illness / injury? No Yes, name of Doctor _____

Internist / Family physician: _____ Referred By: _____

Occupation: _____ Height: _____ Weight: _____

Past Medical History

Serious Illnesses (e.g. tumors, heart attack, high blood pressure): _____

Serious Injuries (e.g. broken bones): _____

Please list all previous surgical procedures and dates: _____

Current medications you are taking: _____

List allergies to medications: _____

Have you ever had a problem with anesthesia? No Yes, when _____

Have you tested positive for a communicable disease? No Yes, when and which disease _____

Social History

Alcohol No Yes Tobacco Smoker/ Chew No Yes

How much per day? _____ How much per day? _____

Review of Present Medical Systems

Circle all that apply

Head Injury, headaches, fainting, convulsions, _____

Eyes Dizziness, disease, corrective lenses, _____

Nose Disease, sinusitis, nosebleeds, allergies, _____

Mouth Dentures, tonsilitis, abscesses, _____

Ears Ringing, discharge, deafness, disease, _____

Neck Thyroid, stiffness, swelling, sore throat, _____

Lungs Chronic cough, night sweats, chest pain, asthma, _____

Heart High blood pressure, heart attack, rheumatic fever,
irregular beat, _____

Stomach Ulcers, diarrhea, bloody stool, constipation, _____

Urinary Infections, kidney stones, kidney dysfunctions, _____

Neurologic Nervousness, weakness, balance problems,

Nervous breakdown, _____

Musculoskeletal Artificial joints, arthritis, bursitis, joint pain, swelling

Family History

Marital Status: _____

Children: _____

Have any of your blood relatives had any of the following?

_____ Cancer

_____ Tuberculosis

_____ Diabetes

_____ Heart Trouble

_____ Low Blood Pressure

_____ High Blood Pressure

_____ Stroke

_____ Epilepsy

_____ Psychological Disorders

_____ Problems with Anesthesia

Signature: _____

(Patient, Parent or Authorized Person)