Medical History

MIAMI BONE & JOINT INSTITUTE

Name: _____ Date: _____

Date of birth: _____ Height: _____ Weight: _____ Social Security #: _____

Dominant hand? Right or Left Acct. #: _____

Was this result of an accident? Yes or No Date of injury: _____

If Yes, it is: ___Automobile ___Work Related ___ Other _____

Describe Injury or Symptoms: _____

Have you seen a Physician in the last 6 months? Yes or No

If yes, Name of Physician and what condition you were treated for: _____

_____

Allergies: None Aspirin Codeine Iodine Morphine Penicillin Sulfa Versed Valium

Other: _____

Please list of medication that you are taking (prescribed or not prescribed): _____

_____ _____ _____

Pharmacy Name: _____ **Phone#:** _____ **Address:** _____

Past or Present Medical History:

*Alzheimer's G30.9
*Anxiety F41.9
*Anemia D64.9
Arthritis
Asthma
*Blindness H54.8
*Cancer _____
Cataracts
*Chronic anxiety F41.1
*Chronic cough R05
Chronic lung disease J44.9
*Chronic sinusitis J32.9
*Cardiovascular Disease I51.9
Colon polyps
*Constipation K59.00
*Crohn's disease K50.90
*Depression F34.9
*Diabetes T1- E10.8 T2 – E11.9
*Diverticulitis K57.92
*Ear / Nose / Throat
*Eating Disorder F50.9
Emphysema
Epilepsy
*Fatty liver K76.0
*Fibromyalgia M79.7
Frequent urinary infection
Gallstones
*Glaucoma H40.9
Gonorrhea
Gout
Groin hernia
Heart attack
Heart murmur

*Hepatitis K73.9
Hiatal hernia
*High blood pressure R03.0
*High cholesterol E79.5
High triglycerides
Hiatal hernia
*HIV/AIDS B20
Iritis
Irregular heart beat
*Irritable bowel syndrome K58.2
Iron Deficiency
*Kidney diseases / failure N18.9/N17.9
Kidney infection
Kidney stones
*Liver Disease K76.9
*Lung Disease J44.9
*Lupus M32.9
*Migraines G43.001
*Multiple Sclerosis G35
*Osteoporosis M81.0
Pancreatitis
*Paralysis G83.9
*Parkinson's G20
*Phlebitis I80.9
Prostate Disease
Pneumonia
Polio
*Psoriasis
Rheumatic Disease
Seizures
Sexually transmitted disease
Stomach/Duodenal ulcer
*Stroke I63.9

Syphilis
TB (tuberculosis)
TB skin test positive
*Thyroid disease E07.9
Ulcerative colitis

Social History/ Marital Status:

Divorced
Married
Separated
Single
Widowed

Social History/ Recreational Drugs:

I have never used recreational drugs
I am currently using recreational drugs
I have been treated for substance abuse

Social History/ Alcohol:

Never
Rarely
Daily
More than 2 days/week
Less than 2 days/week
I quit using alcohol

Social History/ Tobacco:

I use tobacco products
I quit using tobacco products
I have never used tobacco products

Dominant hand:

Right Left

Social History Occupations:

Patient's occupation: _____
Veteran: Yes or No

Social History Hobbies:

Patient hobbies: _____

Musculoskeletal:

None
Back pain
Broken bones
Chronic stiff joints
Disc problems
Swollen joints
Other:_____

Cardiovascular Disease:

None
Abnormal EKG
Angina/chest pain w/activity
Enlarged heart
Pain in legs w/activity
Shortness of breath
Swelling in the legs
Varicose veins
Other:_____

Constitutional:

None
Chills
Fatigue
Fever
Night sweats
Poor appetite
Sweats
Weight gain
Weight loss
Weight stable
Other: _____

Eyes:

None
Blindness
Change in vision
Inflammation
Poor vision
Other: _____

Neurological:

None
Chronic numbness/tingling
Dizziness/Light headiness
Headaches
Weakness in arms
Weakness in legs
Other: _____

Ears, Nose and Throat:

None
Bleeding gums
Chronic sinusitis
Hearing loss
Hoarseness
Ringing in ears
Other:_____

Respiratory:

None
Chronic cough
Cough up blood
Other: _____

Gastrointestinal:

None
Abdominal pain
Bloating
Blood in stool
Constipation
Diarrhea
Heartburn
Jaundice
Nauseas, vomiting
Trouble swallowing
Other: _____

Genitourinary:

None
Blood in urine
Change in urinary frequency
Other:_____

Surgeries/Hospitalizations/Procedures:

None
Breast
Cardiac Surgery
Colonoscopy
Gallbladder surgery
Joint replacement
Trauma
Thyroid
Tonsillectomy
Other:_____
_____

Endocrine:

None
Abnormal growth/ loss of hair
Abnormal hot or cold
Excess thirst
Goiter
Hot flashes
Other:_____
Thyroid

Hematologic:

None
Bleeding doesn't stop easily
Enlarge glands
Frequent bruising
Thrombosis/ blood clots
Transfusions
Other: _____

Psychiatric:

None
Abnormal sleep
Anxiety
Emotional problems
Memory loss/ confusion
Nervous breakdown
Other: _____

Immunizations:

None
Flu
Hepatitis A
Hepatitis B
Other: _____
Pneumonia
Tetanus

Surgical History (indicate surgeries and dates)

_____

Family History	Mother	Father	Siblings
Alive			
Deceased			
Cancer			
Emphysema			
Heart condition			
Hypertension			
Cerebral Infarction			
Diabetes			
Thyroid Disease			
Stroke / Seizures			
Headache			

Patient signature: _____ Date: _____