DuPage Medical Group

ORTHOPAEDICS

Health History Questionnaire

Date: ______________________

Has any information changed since your last visit?

☐ Yes (please describe below) ☐ No

Reported height _______ Reported weight _______

Age ________ Hand Dominance ☐ Right ☐ Left

School (if applicable) ______________________________________ Sport ____

Who is your referring physician? ____

Who is your primary care physician? ____

What is the reason for your visit today? (indicate left or right as appropriate) ____

____

What date did you first experience the above referenced symptoms/injury (date of injury)? _________________________________

Please describe any treatment you have received for these symptoms ____

____

Medical history

Please indicate if you have a problem with any of the following:

☐ Arthritis (*specify*) ________________

☐ Diabetes

☐ Cancer

☐ HIV

☐ High Blood Pressure

☐ High Cholesterol

☐ Hepatitis

☐ Kidney Disease

☐ Sleep Apnea

☐ Stomach Ulcers

☐ Stroke

☐ Other (*specify*) ________________

____

☐ Heart Disease

Have you ever had any surgical procedure? ☐ Yes ☐ No

If yes, please describe ____

____

____

____

Are you taking any medications? ☐ Yes ☐ No

Please list medications and dosages (include over the counter medications) __________________________

____

____

Are you allergic or sensitive to:

☐ Penicillin ☐ Sulfa ☐ Tape/adhesives ☐ Betadine (*iodine*) ☐ Aspirin ☐ None

☐ Tylenol ☐ Ibuprofen ☐ Vicodin ☐ Codeine ☐ Latex ☐ Other (*specify*)

____

Social history

Occupation or grade in school ____

Do you smoke?	☐ Yes	☐ No	If yes:	☐ ½ ppd	☐ 1 ppd	☐ 1 ½ ppd	☐ 2 ppd	
Did you smoke in the past?	☐ Yes	☐ No	How many years did you smoke? _______	When did you quit? _________				
Do you drink alcohol?	☐ Yes	☐ No	If yes:	☐ Socially	☐ 1 daily	☐ 2 daily	☐ >2 daily	
Recreational drug use?	☐ Yes	☐ No	Explain ______________________________					

Family history

Is there any family history (*blood relative*) of
Please indicate all that apply

☐ Arthritis ____________ Type _________	☐ Diabetes _______________	☐ Other (*specify*)
☐ Cancer ____________________________	☐ Heart Disease ___________	______________________
☐ Circulatory Problems _______________	☐ Kidney Disease __________	______________________

Review of systems

Please indicate all that apply

☐ Bruise easily	☐ Diarrhea	☐ Joint pain/swelling	☐ Palpitations	☐ Sore throat
☐ Blurred Vision	☐ Fatigue	☐ Leg swelling	☐ Problem Urinating	☐ Stomach Pain
☐ Chest Pain	☐ Fever, chills	☐ Nausea/vomiting	☐ Rash/Itching	☐ Weakness
☐ Cough	☐ Headaches	☐ Nervousness	☐ Rectal bleeding	☐ Weight Change
☐ Cramps	☐ Hearing Loss	☐ Nose bleeds	☐ Shortness of breath	☐ Wheezing
☐ Depression	☐ Insomnia	☐ Numbness	☐ Skin Ulcers	

Patient Signature ____ Date ____________________

For physician's use Reviewed by __________________________________ Date____________________