DuPage Medical Group

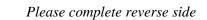
ORTHOPAEDICS

Health History Questionnaire

Date	2:															
Has	any information	on cha	anged si	nce yo	ur last	t visit?										
	Yes (please					No		I								
	orted height							L	_							
-	Age Hand Dominance <pre>Right Left </pre> School (if applicable) Sport															
	o is your referm	01	•													
		-														
Wh	at is the reason	for y	our visit	t today	? (ind	icate le	ft or right a	is appro	priate) _							
Wha	at date did you	first	experier	nce the	above	e refere	nced sympt	toms/in	jury (date	e of inj	jury)? _					
Plea	Please describe any treatment you have received for these symptoms															
Me	edical hist	ory														
Plea	se indicate if y	you ha	ave a pro	oblem	with a	ny of tl	ne followin	ıg:								
	Arthritis (specify)			□ Diabetes			High Blo	igh Blood Pressure			Kidney Disea		ase		Strol	ĸe
				Canc	er		High Cho	olestero	1		Sleep .	Apnea	L		Othe	r (specify)
	Heart Diseas	se		HIV			Hepatitis				Stoma	ch Ulo	cers			
														-		
	Have you ever had any surgical procedure? Yes No															
If ye	If yes, please describe															
Are	Are you taking any medications?															
	se list medicat								ions)							
Are	you allergic o	r sens	itive to:													
	Penicillin		Sulfa			Tape/a	adhesives		Betadin	ne (<i>iod</i>	line)		Aspiri	n		None
	Tylenol		Ibupro	ofen		Vicod	in		Codein	e			Latex			Other (specify)



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ORTHOPAEDICS

Social history

Occupation or grade in school	ol												
Do you smoke?		Yes [] No	If ye	s: 🗆	¹∕₂ ppd		□ 1	ppd 🛛	1 ½ pp	d 🛛 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 ye	s: 🗆	Sociall	y [1 dail	у 🗆 2	daily	\square >2 daily		
Recreational drug use?		Yes 🗆] No	lo Explain									
Family history													
Is there any family history (<i>l</i> <i>Please indicate all that apply</i>		<i>elative</i>) of	•										
Arthritis	Arthritis Type						Diabetes Other (<i>specify</i>)						
Cancer		Heart Disease											
Circulatory Problems		Kidney	Disease										
Review of systems Please indicate all that apply	v												
□ Bruise easily □	Bruise easily 🔲 Diarrhe			Joint pain		ing 🗆 H		Palpitations			Sore throat		
□ Blurred Vision □	Fatigue			Leg swelling				Problem Urinating			Stomach Pain		
□ Chest Pain □	Fever, chills			Nause	Nausea/vomiting			Rash/Itching			Weakness		
□ Cough □	Headaches			Nervo	Nervousness			Rectal bleeding			Weight Change		
□ Cramps □	Hearing Loss 🔲 N			Nose b	Nose bleeds			Shortnes	s of breath		Wheezing		
Depression	Insomnia 🗌 N			Numb	Numbness			Skin Ulcers					
Patient Signature Date													

For physician's use

Reviewed by

Please complete reverse side

Date_