DuPage Medical Group

WE CARE FOR YOU

Health History Questionnaire - Orthopaedics

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 ☐ High Blood Pressure ☐ Kidney Disease ☐ Stroke

☐ Cancer ☐ High Cholesterol ☐ Sleep Apnea ☐ Other (*specify*)

☐ Heart Disease ☐ HIV ☐ Hepatitis ☐ Stomach Ulcers _____

☐ Pulmonary Embolism (PE) Date: _____

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

If yes, please describe _____

_____

_____

_____

Are you taking any medications? ☐ Yes ☐ No

Pharmacy Name: _____ Phone: _____ Address: _____

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*) _____

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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 _____

Please complete reverse side