

# 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:

- |  |                                    |  |   |  |
|--|------------------------------------|--|---|--|
| <input type="checkbox"/> Arthritis ( <i>specify</i> )<br>_____ | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke                            |
| <input type="checkbox"/> Heart Disease                         | <input type="checkbox"/> Cancer    | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Sleep Apnea    | <input type="checkbox"/> Other ( <i>specify</i> )<br>_____ |
| <input type="checkbox"/> HIV                                   | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Ulcers      | _____                                   |  |

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:

- |                                     |                                    |   |   |                                  |  |
|-------------------------------------|------------------------------------|---|---|----------------------------------|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa     | <input type="checkbox"/> Tape/adhesives | <input type="checkbox"/> Betadine ( <i>iodine</i> ) | <input type="checkbox"/> Aspirin | <input type="checkbox"/> None                              |
| <input type="checkbox"/> Tylenol    | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Vicodin        | <input type="checkbox"/> Codeine                    | <input type="checkbox"/> Latex   | <input type="checkbox"/> Other ( <i>specify</i> )<br>_____ |



### 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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Arthritis _____ Type _____ | <input type="checkbox"/> Diabetes _____       | <input type="checkbox"/> Other ( <i>specify</i> ) _____ |
| <input type="checkbox"/> Cancer _____               | <input type="checkbox"/> Heart Disease _____  | _____   |
| <input type="checkbox"/> Circulatory Problems _____ | <input type="checkbox"/> Kidney Disease _____ | _____   |

### Review of systems

Please indicate all that apply

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

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_