

PATIENT INFORMATION FORM

Date: _____

Patient No: _____

Last Name: _____

Patient's Social Security No.: _____

First & Initial: _____

Employer of Insured: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip Code: _____

State: _____ Zip Code: _____

Phone No.: _____ Cell No: _____

Phone No.: _____

Date of Birth: _____ Age: _____

Driver's License No.: _____

Marital Status: S M W D Sex: M F

Primary Language Spoken by Patient/Family: _____

If the patient is a child under 18 years, please give us:

Name of Patient's Parent: _____ Phone No: _____

Parent's Social Security Number: _____

Names of Parent's employers, addresses & phone numbers: _____

What school does child attend? _____

If the patient is married, what is your spouse's name? _____

If spouse is employed, name of employer and phone No.: _____

If you are a patient residing in a nursing home, please give us:

Nursing Home Name: _____ Phone No.: _____

If you have a legal guardian – Name: _____ Phone No.: _____

Insurance Information:

Primary Insurance: _____ Supplemental: _____

Is this a work related injury? Y N

Is this illness or injury related to an accident? Y N If Yes, date: _____

Explanation of accident: _____

Will there be a lawsuit involved due to your accident, injury or illness? Y N

Who may we contact in case of emergency? _____



THE CENTER FOR BONE & JOINT DISEASE
MEDICAL HISTORY

MR# _____
(office use only)

Name: _____ Date: _____

D.O.B. _____ Age: _____ Occupation: _____

Right Handed: _____ Left Handed: _____ Weight _____ Height: _____

Primary Doctor: _____ Phone # _____

Who referred you to us: _____

Describe present symptoms / complaints: _____

When did this problem begin? _____

Is this a work related injury / problem? Yes or No (Please circle)

If so, how did this injury occur? _____

Is an attorney working on your problem? Yes or No (Please circle)

Previous treatment for problem: _____

Does anything make the problem worse? _____

Does anything make the problem better? _____

Did you bring X-Rays with you? Yes or No (Please circle) From Where? _____

Please list any prior surgeries:

Please list any other medical conditions:
(i.e. Hypertension, Diabetes)

List all Medications - give name & dosage:

Allergies to medicine:

Smoking History: Chews Smokes Previously Smoked _____ Packs per day None
Recreational Drugs: Yes No What type - _____
Alcohol History: Never Previously Occasional Moderate to Heavy
Marital Status: Married Single Separated Divorced Widowed # of Children _____
Presently living alone



Name: _____

Date: _____

FAMILY HISTORY

	MATERNAL	PATERNAL
Heart		
Lung		
Stomach		
Liver		
Kidney		
Anemia		
Diabetes		
Mental Illness		

	MATERNAL	PATERNAL
Cancer		
Bleeding Disorder		
Epilepsy/Convulsions		
Stroke		
Thyroid		
Blood Pressure		
Other		

EXPLAIN all Yes answers _____

Have you recently had or do you now have:

	YES	NO
Normal		
Change in appetite		
Chills, fever, sweats		

	YES	NO
Normal		
Frequent Headaches		
Recent Trauma		

	YES	NO
Normal		
Reading Glasses		
Change in Vision		
Double Vision		

	YES	NO
Normal		
Loss of Hearing		
Ringing in Ears		
Gum Problems		
Bleeding		
Nose Bleed		
Hoarseness		
Difficulty Swallowing		
Morning Cough		
Toothache		

	YES	NO
Normal		
Difficulty Breathing		
Cough		
Shortness of Breath		
Short Breath w/Exercise		
Coughing up Blood		

	YES	NO
Normal		
Chest Pain		
Heart Beating Fast		
Difficult Breathing on activity		

	YES	NO
Normal		
Abdominal Pain		
Nausea		
Vomiting		
Bloating		
Diarrhea		
Constipation		
Blood in Stool		
Frequent Belching		

	YES	NO
Normal		
Pain		
Weakness		
Joint Swelling		
Back Pain		
Degenerative Disease		
Neck Pain		

	YES	NO
Normal		
Stroke		
Dizziness		
Loss of Consciousness		
Seizures		
Blackouts		
Nervous/Exhaustion		
Numbness/Tingling		

	YES	NO
Normal		
Rash		
Non Healing lesion		
Itching		

	YES	NO
Normal		
Nervous		
Mood Changes		
Depression		
Insomnia		
Bipolar		
Schizophrenia		

	YES	NO
Normal		
Thyroid		
Heat Intolerance		
Cold Intolerance		
Diabetes		
Excessive Thirst		
Excessive Hunger		
Excessive Urination		

	YES	NO
Normal		
Anemia		
Easy Bruising		
Easy Bleeding		
Swollen Glands		

	YES	NO
None/Normal		
Hayfever		
Environmental Allergies		

	YES	NO
Normal		
Penile Discharge		
Difficulty Urinating		
Blood in Urine		
Get up every night to urinate		
Prostate Trouble		
Frequency		
Hesitancy		
Incontinence		
Dysuria		

	YES	NO
Normal		
Regular Periods		
Menopausal - no periods		
Hysterectomy		
Vaginal Discharge		
Difficulty Urinating		
Blood in Urine		

Spiritual or Cultural Preference? _____ Living Will? Yes No

Healthcare Proxy? Yes No Name _____

Power of Attorney for Healthcare Yes No Name _____

If you have a Power of Attorney, please provide a copy of your POA for your chart. Do Not Resuscitate? Yes No

Reviewed by: _____ Date: _____

Patient Name _____ **Account#** _____

Primary Insurance _____

Policy Holder Name: _____ **DOB** _____

Gender: **Male** **Female**

Social Security Number: _____

Secondary Insurance _____

Policy Holder Name: _____ **DOB** _____

Gender: **Male** **Female**

Social Security Number: _____

