BONE AND JOINT SPECIALISTS
MEDICAL HISTORY QUESTIONNAIRE

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____ Today's Date _____

HEIGHT/WEIGHT

What are your height and weight? _____ ft. _____ in. _____ pounds

MEDICATIONS

Please list any medications you are currently taking: If you have a list, please give it to the receptionist.

_____

_____

_____

_____

OPERATIONS

Have you ever had surgery? (please check one) ☐ No ☐ Yes (If yes, please list operations)

_____

_____

_____

_____

ALLERGIES

Are you allergic to any medication? (please check one) ☐ No ☐ Yes (If yes, please list)

_____

_____

LIFESTYLE

Do you smoke? (please check one) ☐ No ☐ Yes Cigarettes per day? _____ How many years? _____

Do you drink alcoholic beverages? (please check one) ☐ No ☐ Yes If yes, how much daily? _____

History of Drug abuse? (please check one) ☐ No ☐ Yes Are you in pain management? ☐ No ☐ Yes

Have you received your annual: (please check one) Influenza vaccine ☐ No ☐ Yes Pneumonia vaccine ☐ No ☐ Yes

PERSONAL HISTORY

Heart problems? ..... ☐ No ☐ Yes
(Angina, heart attack, chest pain, murmur, valve disease, pacemaker, stents)

Hypertension? ..... ☐ No ☐ Yes
(High Blood Pressure)

High Cholesterol? ..... ☐ No ☐ Yes

Lung problems? ..... ☐ No ☐ Yes
(Emphysema, TB*, asthma, pneumonia)

Liver disease? ..... ☐ No ☐ Yes

Kidney disease? ..... ☐ No ☐ Yes

Ulcers/Gastritis? ..... ☐ No ☐ Yes

Kidney or other Transplants? .... ☐ No ☐ Yes

Blood Clots or PE? ..... ☐ No ☐ Yes

Cancer? ..... ☐ No ☐ Yes
Types _____

Hiatal Hernia? ..... ☐ No ☐ Yes

History of Stroke? ..... ☐ No ☐ Yes

History of Seizures? ..... ☐ No ☐ Yes

Anemia/Sickle Cell? ..... ☐ No ☐ Yes

Bleeding problems or blood thinner? ☐ No ☐ Yes

Recent Cold? ..... ☐ No ☐ Yes

Diabetes? ..... ☐ No ☐ Yes

Thyroid disease? ..... ☐ No ☐ Yes

Other chronic disease? ..... ☐ No ☐ Yes

TURN SHEET OVER

BONE AND JOINT SPECIALISTS
MEDICAL HISTORY QUESTIONNAIRE / PERIODIC SYSTEM REVIEW

Have you recently experienced any of the following? Please check the appropriate answer.

FAMILY HEALTH HISTORY

Please indicate if any member of your immediate family (mother, father, sister, brother, grandparent, or child) has ever been treated for any of the following. If yes, please list the relative's relationship to you.

ILLNESS	RELATIONSHIP TO YOU	ILLNESS	RELATIONSHIP
Stroke	_____	Colitis	_____
Seizures	_____	Kidney Disease	_____
Emphysema	_____	Arthritis	_____
Asthma	_____	Diabetes	_____
High Blood Pressure	_____	Thyroid Disease	_____
Heart Attack	_____	Breast Cancer	_____
High Cholesterol	_____	Colon Cancer	_____
Bleeding Tendency	_____	Prostate Cancer	_____
Ulcer	_____	Other Cancer	_____

PFSH
DETAILED = Pertinent (1 item from either (1) Past, (2) Family or (3) Special History 99203 / 99214 / 99243
COMPREHENSIVE = Complete (1 item from at least 2 or 3 elements for established patient)
(99204 / 99205 / 99215 / 99244/45 or 1 item from all 3 elements for new patients / consultations)

CONSTITUTIONAL SYMPTOMS

Good general health lately?	☐ No	☐ Yes
Recent weight change?	☐ No	☐ Yes
Fever?	☐ No	☐ Yes
Fatigue?	☐ No	☐ Yes
Headaches?	☐ No	☐ Yes

EYES

Eye disease or injury?	☐ No	☐ Yes
Wear glasses or contacts?	☐ No	☐ Yes
Blurred or double vision?	☐ No	☐ Yes

EAR/NOSE/THROAT

Hearing loss or ringing?	☐ No	☐ Yes
Chronic sinus problems?	☐ No	☐ Yes
Nose bleeds?	☐ No	☐ Yes
Sore Throat?	☐ No	☐ Yes
Swollen glands in neck?	☐ No	☐ Yes

CARDIOVASCULAR

Heart trouble?	☐ No	☐ Yes
Chest pain/angina?	☐ No	☐ Yes
Palipitation?	☐ No	☐ Yes
Heart Murmur?	☐ No	☐ Yes
Hypertension?	☐ No	☐ Yes

RESPIRATORY

Chronic Coughs?	☐ No	☐ Yes
Shortness of breath?	☐ No	☐ Yes
Asthma?	☐ No	☐ Yes
Emphysema?	☐ No	☐ Yes

GASTROINTESTINAL

Loss of appetite?	☐ No	☐ Yes
Nausea/vomiting?	☐ No	☐ Yes
Frequent diarrhea?	☐ No	☐ Yes
Constipation?	☐ No	☐ Yes
Abdominal pain?	☐ No	☐ Yes

MUSCULOSKELETAL

Joint Pain?	☐ No	☐ Yes
Joint stiffness or swelling?	☐ No	☐ Yes
Weakness of muscles?	☐ No	☐ Yes
Muscle pain / cramps?	☐ No	☐ Yes

GENITOURINARY

Frequent urination?	☐ No	☐ Yes
Burning / painful urination?	☐ No	☐ Yes
Blood in urine?	☐ No	☐ Yes
Hernia?	☐ No	☐ Yes

INTEGUMENTARY

Rash or itching?	☐ No	☐ Yes
Change in skin color?	☐ No	☐ Yes
Change in hair or nails?	☐ No	☐ Yes

NEUROLOGICAL

Frequent headaches?	☐ No	☐ Yes
Light headed/dizzy?	☐ No	☐ Yes
Numbness / tingling?	☐ No	☐ Yes
Seizures / tremors?	☐ No	☐ Yes
Paralysis?	☐ No	☐ Yes

PSYCHIATRIC

Memory loss / confusion?	☐ No	☐ Yes
Nervousness?	☐ No	☐ Yes
Depression?	☐ No	☐ Yes
Insomnia?	☐ No	☐ Yes

FOR INTERNAL USE ONLY

EXPANDED. PROBLEM FOCUSED = Problem pertinent - 99202 / 99213 / 99242 (1 System) - Chief complaint / Recent Occurrence
DETAILED = 2-9 Systems 99203 / 99214 / 99243 - Chief complaint evolved over time
COMPREHENSIVE = 10+ Systems

Patient/Parent Signature: _____ Date: _____

Physician Signature: _____ Date: _____