

Midwest Bone & Joint Specialists  
396 Remington Blvd., Suite 240  
Bolingbrook, IL 60440



Date: \_\_\_\_\_

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SEX: M / F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home #: \_\_\_\_\_ Day #: \_\_\_\_\_  
Alternate #: \_\_\_\_\_ Referring Dr.: \_\_\_\_\_  
Parent Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Insurance Information**

Primary Ins.: \_\_\_\_\_ Secondary Ins.: \_\_\_\_\_  
ID #: \_\_\_\_\_ ID #: \_\_\_\_\_  
Group #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

**Workman's Compensation**

Plan Name: \_\_\_\_\_ Date of Injury \_\_\_\_\_  
Address: \_\_\_\_\_ Authorization #: \_\_\_\_\_  
Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

I, the patient or responsible, certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all bills at the time of service unless other arrangements are made. I authorize physician and insurance claims to be paid to the practice or its representative.

Patient/Responsible Signature \_\_\_\_\_ Date \_\_\_\_\_



- ◆ Flank pain
- ◆ Urine odor
- ◆ Frequency
- ◆ Groin mass
- ◆ Blood in urine
- ◆ Incontinence
- ◆ Urgency
- ◆ Change in urine color

*Reproductive*

Male

- ◆ Pain
- ◆ Testicular mass
- ◆ Infertility
- ◆ Blood in the semen/hemospermia
- ◆ Testicular pain
- ◆ Discharge
- ◆ Herpes genitals
- ◆ Circumcised
- ◆ Lack of libido/sexual drive
- ◆ History of hydrocele

Female

- ◆ Irregular menses
- ◆ Menstrual problems
- ◆ Amenorrhea/absence of menses
- ◆ Menorrhagia/heavy-prolonged menses
- ◆ Pregnant-current
- ◆ Dysmenorrheal/painful menses
- ◆ Infertility
- ◆ Breast lump
- ◆ Menopause
- ◆ Breast pain
- ◆ Breast discharge

*Metabolic/Endocrine*

- ◆ Goiter
- ◆ Cold intolerance
- ◆ Voice change
- ◆ Weight gain \_\_\_\_ lbs
- ◆ Weight loss \_\_\_\_ lbs
- ◆ Hair loss
- ◆ Heat intolerance
- ◆ Diabetes
- ◆ Excessive perspiration
- ◆ Low blood sugar
- ◆ Frequent urination/polyuria
- ◆ Excessive hunger/polyphagia
- ◆ Excessive thirst/polydipsia

*Nervous System/Psychiatric*

- ◆ Headaches
- ◆ Sleep apnea
- ◆ Loss of conscious/fainting
- ◆ Speech changes
- ◆ Depression
- ◆ Stroke
- ◆ Seizures
- ◆ Vertigo/dizziness
- ◆ Difficulty in articulating words/dysarthria
- ◆ Anxiety
- ◆ Meningitis
- ◆ In coordination
- ◆ Bipolar
- ◆ Memory loss
- ◆ Light-headed

*Skin*

- ◆ Excessive sun
- ◆ Contact allergy
- ◆ Acne
- ◆ Hair loss
- ◆ Severe itching
- ◆ Rash where?
- ◆ Skin lesions where?
- ◆ Pigment change
- ◆ Nail changes
- ◆ Excessive growth of facial or body hair (women)/ Hirsutism
- ◆ Frequent infection

*Musculoskeletal*

- ◆ Back pain
- ◆ Heel pain
- ◆ Myalgias/muscle pain
- ◆ Weakness
- ◆ Neck stiffness
- ◆ Bunions
- ◆ Hammer toes
- ◆ Plantar warts
- ◆ Bone/joint symptoms
- ◆ Stiff joints
- ◆ Painful joints
- ◆ Swollen joints
- ◆ Arthritis
- ◆ Broken bones, which bones?

*Blood*

- ◆ Anemia
- ◆ Prior transfusion
- ◆ Clotting disorder
- ◆ HIV/AIDS
- ◆ Easy bruising
- ◆ Easy bleeding
- ◆ Taking blood thinners

*Allergy/Immunologic*

- ◆ Asthma
- ◆ Hay fever
- ◆ "Bee" sting allergies
- ◆ Animals at home
- ◆ Contact dermatitis
- ◆ Hives
- ◆ Food allergies
- ◆ Environmental allergies
- ◆ Animal at workplace
- ◆ Chemicals at home
- ◆ Chemicals at workplace

Family History:

Do any of the above to parents/siblings/children? If so, who? \_\_\_\_\_  
 What? \_\_\_\_\_

Social History:

Did you ever smoke? ◆ Yes ◆ No      How much? \_\_\_\_\_ packs/day for years  
 If you quit, when? \_\_\_\_\_

Do you drink alcohol? ◆ Yes ◆ No      How much? \_\_\_\_ per ◆ day ◆ week ◆ month ◆ year  
 ◆ socially

Have you ever used non-prescription (illicit) drugs? ◆ Yes ◆ No  
 What drugs have/do you use? \_\_\_\_\_  
 Last used? \_\_\_\_\_ Any ever injected? \_\_\_\_\_

Do you consume caffeine? ◆ Yes ◆ No      How much? \_\_\_\_\_ ◆ daily ◆ weekly ◆ monthly

**Patient History**

Name (last, First, MI)	_/_/	_/_/	Sex: Male / Female
	Date of Birth		

Were you referred by this Dr.?  yes  no  
or someone else? \_\_\_\_\_

Primary Care Physician/Family Dr. \_\_\_\_\_

Person's Name \_\_\_\_\_

May we share information with: Primary Care Physician?  yes  no Referral Person?  yes  no

Who do you work for? (Company name) \_\_\_\_\_

Job Title \_\_\_\_\_

What do you do? What does your job require? (i.e. Lift heavy objects, desk work, repetitive work, on feet a lot) Please describe: \_\_\_\_\_

Are you:  single  married  divorced  widowed

Do you live with someone else?  yes  no If yes, no? \_\_\_\_\_

Allergies			
Medication	Reaction you had	Medication	Reaction you had
Food	Reaction you had	Food	Reaction you had

Environmental (i.e. Hay fever, dust): \_\_\_\_\_

<input checked="" type="checkbox"/> Inactive /Date	Medications Name – Dose/strength	How often do you take it	<input checked="" type="checkbox"/> As Needed
<input type="checkbox"/>			<input type="checkbox"/>
<input type="checkbox"/>			<input type="checkbox"/>
<input type="checkbox"/>			<input type="checkbox"/>
<input type="checkbox"/>			<input type="checkbox"/>
<input type="checkbox"/>			<input type="checkbox"/>
<input type="checkbox"/>			<input type="checkbox"/>
<input type="checkbox"/>			<input type="checkbox"/>
<input type="checkbox"/>			<input type="checkbox"/>

Surgeries	Year	Other Surgeries	Year
<input type="checkbox"/> Cataracts – <input type="checkbox"/> Right – <input type="checkbox"/> Left			
<input type="checkbox"/> Tonsillectomy/Adenoidectomy			
<input type="checkbox"/> Heart – <input type="checkbox"/> Bypass – <input type="checkbox"/> Angioplasty			
<input type="checkbox"/> Cholecystectomy (gallbladder)			
<input type="checkbox"/> Appendectomy			
<input type="checkbox"/> Hysterectomy			
<input type="checkbox"/> C-section – How many?			

**Midwest Bone & Joint Specialists**

**History Present Illness – New Problem**

_____ / ____ / ____ Name (Last, First, MI)	_____ / ____ / ____ Date of Birth	_____ Age	____ / ____ / ____ Today's Date
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*Please be as specific as possible when you answer the following questions. Answer all questions*

Who is with you today (names, relationship to you)? \_\_\_\_\_

What problem are you here for today (briefly)? \_\_\_\_\_

(If more than one problem, please speak with receptionist)

Which side is involved?  Right  Left When did this first start? \_\_\_\_\_

How did this start? What were you doing when you first noticed this (If an accident, include exact date & location)? \_\_\_\_\_

Where is your pain? Be specific. \_\_\_\_\_

Does it radiate?  yes  no Where does it radiate to? \_\_\_\_\_

Describe how it feels, what it feels like: \_\_\_\_\_

How severe is the pain? \_\_\_\_\_

What makes the pain/problem worse? \_\_\_\_\_

What makes the pain/problem better? \_\_\_\_\_

What have you tried for it so far (include everything, i.e. ice, medications, therapy, etc.)? \_\_\_\_\_

Is it:  constant  intermittent Is it getting:  better  worse  staying the same

Any swelling:  yes  no where? \_\_\_\_\_

Do you note any weakness?  yes  no where? \_\_\_\_\_

Do you note any numbness, tingling?  yes  no where? \_\_\_\_\_

Is it:  constant  intermittent What causes it? \_\_\_\_\_

Have you ever had any problems in this past with this extremity (any type)?  yes  no

What problems? \_\_\_\_\_

**MIDWEST BONE & JOINT SPECIALISTS**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

**Please tell us how you learned about our practice**

- I saw an ad in the local newspaper
- I got information from the internet
- By my insurance company
- By a friend or family member
- Another doctor – Doctor's name: \_\_\_\_\_
- Other: \_\_\_\_\_