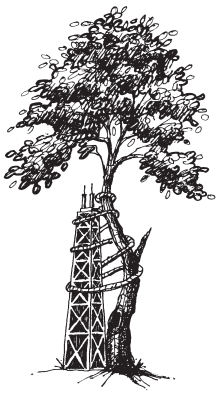

WINDY CITY ORTHOPEDICS AND SPORTS MEDICINE

MEDICAL HISTORY QUESTIONNAIRE

2617 W. Peterson Ave. Chicago, Illinois 60659 www.Jockdoc.net
Toll Free 877-549-4490 Suburban 847-475-0200 Chicago 773-743-1981

Patient Name_____ **Date** _____/_____/_____

THIS IS A CONFIDENTIAL QUESTIONNAIRE. PLEASE ANSWER EACH QUESTION AS COMPLETELY AS POSSIBLE THIS INFORMATION WILL HELP DR. MILLER TO PROVIDE YOU WITH THE BEST POSSIBLE CARE.

Are you now taking medication of any kind (including aspirin, Tylenol, homeopathic or herbal) on a regular basis? NO

Name	Amount/day	Date started	Name	Amount/day	Date started

Your Pharmacy Phone(____)_____-_____ CVS Osco Target Walgreen's Walmart Other (Please Circle)

Pharmacy Address _____

Do you have an allergy (hives, rashes, swollen lips or shortness of breath) or have a serious reaction to any medication, anesthesia, food, or compound used internally or on the skin? NO

Name	Type of Reaction	Name	Type of Reaction

Have you previously been a patient in a hospital? NO

Year	Reason	Place

Have you had any other surgery or serious illness, injury or disability? NO

Year	Reason	Place

Do you smoke now or have you been a smoker? If yes, please describe. NO

_____ Pack(s) per day for _____ years I quit! ___ year(s) ago Other _____

Please Circle If <u>YOU</u> or <u>ANYONE IN YOUR FAMILY</u> Have Ever Had Any of the Following

	You	Family		You	Family
Scarlet Fever	YES	YES	Stomach Ulcers	YES	YES
Rheumatic Fever	YES	YES	Venereal Disease	YES	YES
Poliomyelitis	YES	YES	Asthma, Hay Fever, Or Hives	YES	YES
Hepatitis	YES	YES	Bleeding Tendencies	YES	YES
Tuberculosis	YES	YES	Cancer or Tumor	YES	YES
Mumps High	YES	YES	Blood Pressure	YES	YES
Kidney Trouble	YES	YES	Diabetes	YES	YES
Heart Trouble	YES	YES	Thyroid Trouble	YES	YES
Measles	YES	YES	Alcoholism/Drug Dependency	YES	YES
Osteoporosis/Fracture	YES	YES	AID's/HIV +	YES	YES
Paget's Disease	YES	YES	Stroke/Cerebrovascular Accident	YES	YES
Osteomyelitis	YES	YES	Rheumatoid Arthritis	YES	YES

Please Check (✔) All Those Complaints That You Have Had in the Last Year and Circle All Those that You Have Had in the Last Month

MISCELLANEOUS
__ Fever
__ Depression
__ Weight loss
__ Skin rashes
__ Poor or change in appetite
__ Loss or lack of energy

EYE AND EAR PROBLEMS
__ Double or blurred vision
__ Colored rings around lights
__ Injury to the eyes
__ Temporary loss of vision
__ Infection of the eyes
__ Painful eyes
__ Discharge or ringing in the ears
__ Hearing Loss

HEART, LUNGS, CIRCULATION
__ Heart murmur
__ Shortness of breath with little effort or lying flat
__ Swelling of feet or ankles
__ Coughing up blood
__ Cramps in legs when walking
__ High blood pressure
__ Wheezing or noisy breathing
__ Varicose vein problems
__ Rapid, pounding, or irregular heartbeat
__ Chest pains or tightness
__ Recurrent or persistent cough
__ Soaking sweats at night time
__ Phlebitis (vein inflammation or blood clots)

STOMACH DIFFICULTIES
__ Difficult or painful swallowing
__ Heartburn or discomfort
__ Poor or change in appetite
__ Painful or sore abdomen
__ Nausea or vomiting
__ Unusual bloating, burping, or passing gas
__ Loose, painful, gray, black, or bloody stools for more than 1/day
__ Soreness, pain, or bleeding from rectum
__ Jaundice

BLOOD DISORDERS OR BLEEDING
__ Anemia or abnormal blood count
__ Do you bruise easily? YES NO
__ Frequent nosebleeds
__ "Swollen glands"
__ Do you take aspirin on a regular basis?

MUSCULAR, BRAIN, OR NERVE DISORDERS
__ Serious head injury
__ Frequent or severe headaches
__ Fainting or dizziness
__ Fits, seizures, or epilepsy
__ Twitching, shaking, or trembling
__ Unusual loss of coordination, balance or strength
__ Loss of smell, taste, etc.

URINARY OR GENITAL PROBLEMS
__ Pain, burning, brown or bloody urination
__ Difficulty starting urination
__ Urinating more than 6-8 times a day or night
__ Trouble holding urine
__ Pus or protein in urine
__ Kidney stones
__ Sores on the genitals

MEN, DO YOU HAVE
__ Weak or slow urine stream
__ Prostrate trouble
__ Discharge from the penis
__ Swollen or painful testes

WOMEN, DO YOU HAVE
__ Irregular, abnormal or painful periods
__ Excessive vaginal discharge or soreness
__ Are you pregnant now? YES NO

BONE, JOINT PROBLEMS
__ Painful, swollen, or stiff joints or back
__ Fractures or Dislocations
__ Arm or Leg Deformity
__ Cracking, Popping, or Noises in the Spine or Joints
__ I Have Needed Cortisone Injections into My Joints or Back
__ I Have Used Aspirin or Aspirin-like Drugs for my Joints

COMMENTS: _____