# MEDICAL HISTORY FORM

Date

## PATIENT INFORMATION

**Name** *(First) (Middle) (Last)* ◯ Male ◯ Female

**Age** **Date of Birth** **Right or Left handed?** ◯ Right ◯ Left

**Working Status** ◯ Working ◯ Retired ◯ Disabled

**Occupation**

## PHYSICIANS

**Referring Physician** *(First) (Last)* **Telephone**

**Primary Care Physician** *(First) (Last)* **Telephone**

## MEDICAL INFORMATION

**Chief Complaint** *(Example: Right hip pain)*

**Date of injury or onset of symptoms**

**Describe your symptoms** *(Example: a sharp pain when I walk)*

**How did the injury happen?**

**Symptom Relief** *(Example: rest, heat/cold, therapy, medication)*

**Symptom Aggravation** *(Example: activity, movement)*

**Additional Symptoms**

**Describe Treatment**

**Have you had any diagnostic tests for this problem?** ◯ Yes ◯ No **If Yes, what & where?**

**Has a physician recommended that you have surgery for this problem?** ◯ Yes ◯ No

**Name of previous treating physician(s), if any?**

**PAST MEDICAL HISTORY**

**PAST SURGICAL HISTORY** *(Please list the surgical procedure, date of procedure and complications)*

**Have you ever had problems with anesthesia?** ◯ Yes ◯ No

**If yes, describe:**

Patient Name_____

## SOCIAL HISTORY

**Student?** ◯ Yes ◯ No

**School** _____ **Grade** _____

**Sport** _____

**Marital Status** ◯ Single ◯ Married ◯ Divorced ◯ Widowed

**Do you live alone?** ◯ Yes ◯ No

**Alcohol use** ◯ Never ◯ Occasional ◯ Daily ◯ Heavy

**History of alcoholism?** ◯ Yes ◯ No

**History of drug use?** ◯ Yes ◯ No

**FAMILY HISTORY**

## MEDICATIONS *(Prescription / Nonprescription / Herbal supplements / Vitamins / Other)*

| Medication Name | Dosage | Medication Name | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Are you taking low-dose Aspirin?** ◯ Yes ◯ No

**Are you taking Anti-coagulants?** ◯ Yes ◯ No

**Are you taking Corticosteroids?** ◯ Yes ◯ No

**Have you taken at least two different anti-inflammatory medications for your condition?** ◯ Yes ◯ No

**If Yes, how long?** _____

**ALLERGIES (***Please list type of allergy (medications, latex, metals, etc) and type of reaction you experience)*

## RISK FACTORS

**Tobacco use** ◯ Never Smoked ◯ Former Smoker **Are you a current smoker?** ◯ Yes ◯ No

**Height** _____ **Weight** _____ **BP** _____ \ _____

Patient Name_____

**REVIEW of SYSTEMS** ***(****Have or do you ever experience any of the following signs or symptoms? If yes please describe)*

| Sign/Symptom | Yes/No | Describe all "Yes" responses |
|---|---|---|
| Eyes (e.g. blurred vision, double vision, loss of vision) | ◯ Yes ◯ No | |
| Ears, Nose, Throat (e.g. sore throat, earache, ringing) | ◯ Yes ◯ No | |
| Cardiovascular (e.g. chest pain, palpitations) | ◯ Yes ◯ No | |
| Respiratory (e.g. shortness of breath, cough, snore) | ◯ Yes ◯ No | |
| Gastrointestinal (e.g. ulcer, gastritis, GI bleed) | ◯ Yes ◯ No | |
| Genitourinary (e.g. burning, bleeding) | ◯ Yes ◯ No | |
| Musculoskeletal (e.g. joint, muscle, back or neck pain) | ◯ Yes ◯ No | |
| Skin (e.g. delayed healing, rash, acne, cellulitis) | ◯ Yes ◯ No | |
| Neurological (e.g. numbness, tingling, weakness) | ◯ Yes ◯ No | |
| Endocrine (e.g. weight gain/loss, excess thirst or urine) | ◯ Yes ◯ No | |
| Hematologic (e.g. bruising, bleeding, clotting disorder) | ◯ Yes ◯ No | |
| Allergic / Immunologic (e.g. rash, swelling, wheezing) | ◯ Yes ◯ No | |

**COMMENTS OR CLARIFICATION**

**Patient/Guardian Statement:**

To the best of my knowledge, the above information is accurate and complete.

**Patient Signature** **Signed Date**

**Guardian Signature** ***(if patient is a minor)*** **Signed Date**

**Guardian Printed Name**

**Provider Statement:**

I have reviewed the questionnaire with the patient.

**Any Changes?**

◯ Yes ◯ No **Signed** **Date**

◯ Yes ◯ No **Signed** **Date**

◯ Yes ◯ No **Signed** **Date**

Account #

# PATIENT INFORMATION

**Name** *(First) (Middle) (Last)* ◯ Male ◯ Female

**Age** **Date of Birth**

**SSN** **Marital Status** ◯ Single ◯ Married ◯ Divorced ◯ Widowed

**Address** **City** **State** **Zip Code**

**Home Telephone** **Work Telephone** **Cell Telephone**

**Email** **May we email you newsletters?** ◯ Yes ◯ No

**Preferred Language** **Ethnicity** ◯ Hispanic ◯ Non-Hispanic **Race**

## PHYSICIANS / PHARMACY

**Referring Physician** *(First) (Last)* **Telephone**

**Primary Care Physician** *(First) (Last)* **Telephone**

**Pharmacy Name** **Telephone**

**Address**

## GUARANTOR

☐ Guarantor Same As Patient **Relationship** **Telephone** **Date of Birth**

**Name** *(First) (Middle) (Last)* ◯ Male ◯ Female

**SSN** **Occupation** **Employer**

**Address** **City** **State** **Zip Code**

## PATIENT EMPLOYMENT AND EMERGENCY CONTACT

**Employment Status** ◯ Working ◯ Retired ◯ Disabled **Emergency Contact**

**Occupation** **Telephone**

**Employer** **Relationship**

## INSURANCE CARRIERS

| | Carrier #1 | Carrier #2 |
|---|---|---|
| **Name** | | |
| **Policy/Claim #** | | |
| **Group ID** | | |
| **Policy Holder** | | |
| **Policy Holder DOB** | | |

**Work Related?** ◯ Yes ◯ No

**Work Comp Insurance** **Work Comp Contact**

**Insurance Address** **Contact Telephone**

**Claim #**

**Insurance Telephone**

I hereby authorize Fox Valley Orthopedics to release any information to my insurance company acquired in the course of my examination or treatment. I hereby authorize benefits to be paid directly to them. I authorize them to check pharmacies for my prescription history. I understand I am responsible for any unpaid balance.

**Patient Signature** *(Guardian if Patient is a minor)* Print Form **Date**

Patient Name_____

## PLEASE SIGN & DATE:

I confirm that the privacy policy has been made available to me.

X_____Date:_____

Patient Signature (Guardian if Patient is a minor)

## CONFIDENTIAL COMMUNICATION REQUEST

May we leave a message regarding medical information, please check your answer:

| | | |
|---|---|---|
| On answering machine at home? | ☐ Yes | ☐ No |
| With person at your home? | ☐ Yes | ☐ No |
| On your voicemail at work? | ☐ Yes | ☐ No |
| On your email account? | ☐ Yes | ☐ No |
| On your voicemail on your cell phone? | ☐ Yes | ☐ No |

May we speak to a family member regarding your medical status? If so, with whom may we speak?

_____

X_____

Patient Signature (Guardian if Patient is a minor)

May we speak to a family member regarding your financial status? If so, with whom may we speak?

_____

X_____

Patient Signature (Guardian if Patient is a minor)

## RELEASE OF LABORATORY & X-RAY INFORMATION

I hereby authorize Fox Valley Orthopedics to give lab, X-Ray, MRI, and CT results to a family member:

X_____

Patient Signature (Guardian if Patient is a minor)

## ACKNOWLEDGEMENT REGARDING MEDICAL EQUIPMENT

Not all medical equipment may be paid for by my insurance company. We will let you know which items may not be covered. If my insurance carrier denies payment, I agree to be personally and fully responsible for payment.

X_____

Patient Signature (Guardian if Patient is a minor)


FOX VALLEY ORTHOPEDICS

**fvortho.com**

**ELGIN**
2350 Royal Boulevard
Suite 200
Elgin, IL 60123
847.931.5300

**ELGIN**
1710 Randall Road
Suite 140
Elgin, IL 60123
224.293.1170

**BARRINGTON**
420 W. Northwest Highway
Suite M
Barrington, IL 60010
847.382.6766

**GENEVA**
308 Randall Road
Suite A
Geneva, IL 60134
630.262.5391

**ALGONQUIN**
2971 W. Algonquin Road
Suite 101A
Algonquin, IL 60102
847.854.8590