

**BONE & JOINT ASSOCIATES, LLP  
MEDICAL HISTORY**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

**List Any Medical Conditions:** \_\_\_\_\_

\_\_\_\_\_

**Medications:** \_\_\_\_\_

\_\_\_\_\_

**Allergies to Medication:** \_\_\_\_\_

\_\_\_\_\_

**List Any Prior Surgeries (and year):** \_\_\_\_\_

\_\_\_\_\_

Have you ever had general anesthesia?  Yes  No  
If "yes" were there any problems?  Yes  No Describe: \_\_\_\_\_

**DO YOU HAVE A FAMILY HISTORY OF:**

Heart Disease  Mother  Father Other: \_\_\_\_\_  
 Diabetes  Mother  Father Other: \_\_\_\_\_  
 Other Illness: \_\_\_\_\_  Mother  Father  
\_\_\_\_\_  Mother  Father

**SOCIAL HISTORY**

History of substance abuse:  Yes  No  
I currently drink alcohol:  Never  Daily  1-2x/week  1-2x/month  1-2x/year  
I currently smoke tobacco products/cigarettes:  Yes  No  
If yes, for how long? \_\_\_\_\_ How many packs a day do/did you smoke? \_\_\_\_\_

Current Height \_\_\_\_\_ Weight \_\_\_\_\_

**DESCRIBE YOUR PAIN/LOCATION:** \_\_\_\_\_

**RATE YOUR PAIN (0=NO PAIN, 10=EXTREME PAIN): 0 1 2 3 4 5 6 7 8 9 10**

When are you affected the most:  Morning  Midday  Night

What makes it better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Have you ever injured this body part before?  Yes  No If Yes, who treated you? \_\_\_\_\_

Did you require surgery?  Yes  No If Yes, when and the surgeons name: \_\_\_\_\_

**HAVE YOU HAD:**

- X-RAYS
- MRI
- CT SCAN
- ULTRASOUND

**WHEN, WHERE AND LIST TYPE:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- PHYSICAL THERAPY
- OCCUPATIONAL THERAPY
- MEDICATIONS
- INJECTIONS
- BRACES
- ORTHOTICS OR SPECIAL SHOES

**DID THIS HELP?**

- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No
- Yes  No

**Physician Signature:** \_\_\_\_\_

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