Big Horn Basin Bone & Joint, LLC

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Health History

Name _____ Age _____ Were you referred by a physician? Yes _____ No _____
Who requested our services? _____ Family physician: _____
Reason for seeking medical attention: _____ Right: _____ Left: _____ Both: _____
Describe the cause of the symptoms or injury: _____
_____
Date of injury or duration of symptoms: _____ Work related? _____ Are you right or left handed (R,L) _____
Have you had any diagnostic studies for this condition, such as MRI, bone scan, etc.? Please list: _____
_____
Have you seen anyone else regarding this condition? _____ If yes, please list names and dates: _____
Have you ever been diagnosed with any of the following medical conditions? (Y = yes, N = no)

_____ Asthma	_____ Hepatitis	_____ Nervous system disorder	_____ Colitis
_____ Kidney disease	_____ Anemia	_____ Osteoarthritis	_____ Polio
_____ Lupus	_____ Migraines	_____ Alcoholism	_____ COPD
_____ Bleeding tendencies	_____ Diabetes	_____ Rheumatoid Arthritis	_____ Gout
_____ Heart disease	_____ Lung disease	_____ Sickle Cell Anemia	_____ Cancer
_____ Epilepsy	_____ Tuberculosis	_____ Stomach ulcers	_____ Thyroid
_____ High blood pressure	_____ Anxiety/Depression	_____ Elevated Cholesterol	_____ Stroke

Other medical conditions: _____
Please list any orthopedic surgeries and dates: _____
_____
Please list all current medications and dosages: _____
_____
_____
_____

Are you allergic to any of the following (check if you are)?

_____ Penicillin	_____ Cephalosporin	_____ Aspirin	_____ Latex	_____ Dyes
_____ Arthritis Meds	_____ Adhesive tape	_____ Morphine	_____ Sulfa	_____ Iodine
			_____ Codeine	_____ Mycin

Foods (please list): _____
Others: _____
Do you currently use tobacco? Cigarettes _____ Pipe _____ Smokeless _____ Amt/day _____ Quit (when)? _____
Do you drink alcohol? _____ Beer _____ Liquor _____ Wine _____ Amt/day _____
What is your current occupation? _____

Family History:
Has anyone in your family had any of the following:

_____ High blood pressure	_____ Cancer	_____ Diabetes	_____ Bleeding problems
_____ Lung disease	*if yes, what type of cancer?		

Have you had any of the following problems or symptoms (Y = yes, N = no)?

_____ Chest pain	_____ Loss of bowel control	_____ Fainting spells
_____ Breathing difficulty	_____ Cough	_____ Cough with blood
_____ Numbness or tingling	_____ Dizziness	_____ Migraines
_____ Vision changes	_____ Nausea/vomiting	_____ Diarrhea
_____ Abdominal pain	_____ Headaches	_____ Difficulty starting urine
_____ Bloody or black tarry stools	_____ Fever/chills	_____ Loss of bladder control
_____ Pain/burning on urination	_____ Weight loss	_____ Depression/anxiety
_____ Irregular heart beat	_____ Blood in urine	_____ Other _____

Patient's signature _____ Date: _____

For office use only: Height _____ Weight _____ BP _____ Pulse _____