



ILLINOIS BONE AND JOINT INSTITUTE, LLC®

Lake Shore Orthopaedics

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Dear Patient,

Welcome to our practice and thank you for placing your trust in us. We look forward to providing your Orthopaedic care and would like to provide you in advance with important registration information.

Please complete the enclosed health history forms and bring them with you to your appointment. Each form contains pertinent information that we require for clinical purposes.

- If you take several medications, it is helpful to have a separate list reporting each drug currently prescribed including the name of the drug and the dosage.
- If you have had recent x-rays (plain films, CT or MRI) or other tests relating to the condition that you're seeking evaluation for, please bring a copy of the images (films or CD), radiology report and/or other test results with you to your appointment. You may also request that copies of your medical records be either mailed or faxed to our office. Our fax number is (847) 336-3249.
- Please bring your insurance card and photo ID. Copies of these documents will be retained on file as this information is needed for billing and insurance purposes. Depending on the type of coverage you have, a referral may be required. Please check your plan requirements.
- If you have a co-payment, payment is due at the time of service. Your insurance card will usually display your co-payment requirement, if any, for office or specialists.
- Depending on the nature of your visit and whether radiology or other services are needed, your appointment can take up to 30 minutes and sometimes longer.
- Should you need to cancel or reschedule your appointment, we kindly ask that you promptly call our office at (847) 336-3335 so the appointment can be reserved for another patient needing specialized Orthopaedic care. We understand that there are unforeseen events that may result in a missed appointment; in these situations, we ask that you notify us as soon as possible so we can reschedule your appointment. However, in all other situations, we will be assessing a \$25 fee for missed appointments.

Due to the specialty and surgical nature of our practice, the physicians are often called upon by other physicians and area hospitals to see patients on an emergency basis. Although we strive to be on time for appointments, emergency surgeries and patient appointments do occur. Our Front Desk Staff will notify you if there is an appointment delay due to an emergency. We truly respect and value your time and appreciate your understanding when an emergency occurs. We look forward to your upcoming visit.

Sincerely,
IBJI – Lake Shore Orthopaedics

Today's Date: _____

Last IJBI Visit Date: _____

MEDICAL HISTORY FORM

PATIENT INFORMATION

Name (First) _____ (Last) _____ (Middle) _____

Age: _____ Date of Birth _____ Sex: M F

Height: _____ Weight: _____ lbs Rt or Lt Handed

Occupation _____

Working now? yes no retired disabled

PREFERRED PHARMACY

Pharmacy: _____

Address: _____

Phone: _____

HISTORY OF PRESENT ILLNESS

Reason for today's visit: _____

REFERRING PHYSICIAN

Name _____

Street _____ Suite _____

City _____ State _____ Zip Code _____

Phone _____

PRIMARY CARE PHYSICIAN (if different than above)

Name: _____

Address: _____

Phone: _____

* If your visit is related to an injury, circle the appropriate response in the box below. If it is not related to an injury, skip this box.

The injury is due to: car accident / work injury / sports injury / fall / other _____

The injury occurred at: home / work / school / other _____

Are you off work due to the injury? yes / no If yes, last day worked _____ If no, any restrictions _____

Is legal action / litigation pending due to this injury? yes / no

DATE of onset / injury ____ / ____ / ____ SYMPTOMS _____

LOCATION of symptoms: _____ If the problem is in an arm or leg, is it: right left both

Circle each characteristic that best describes your problem:

QUALITY: Sharp / Dull / Throbbing / Aching / Burning / Cramping

SEVERITY: Mild / Moderate / Severe

DURATION: Infrequent / Intermittent / Constant / Hourly / Daily / Weekly

TIMING: During Activity / After Activity / Walking / Running / Stairs / Squatting / Pivoting / Overhead use / Throw / Lift / Other

CONTEXT: Improving / Worsening / Recurrent / More Frequent / Less Frequent / Unchanged

SYMPTOM RELIEF: Rest / Heat / Cold / Elevation / Physical Therapy / Brace / Injection / Medication / Other: _____

SYMPTOM AGGRAVATION: Activity / Position Change / Repetitive Motion / Fatigue / Other: _____

ASSOCIATED SYMPTOMS: _____

TREATMENT Describe treatment and response for current problem _____

Have you had a problem with this area before? yes no If yes, describe problem and prior treatment: _____

Have you had any diagnostic tests for this problem? yes no If yes, what and where? _____

Did you bring them with you? yes no Do you have a copy of the test results? yes no

Has a physician recommended that you have surgery for this problem? yes no

Name of previous treating physician(s), if any: _____

REVIEW of SYSTEMS:

Have you ever experienced or do you currently have any of the following signs or symptoms? If "Yes", please describe:

SYMPTOMS	Yes	No	Describe all "Yes" responses
Eyes (e.g. blurred vision, double vision, loss of vision)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat (e.g. sore throat, earache, ringing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (e.g. chest pain, palpitations, ankle swelling)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory (e.g. shortness of breath, cough, snore)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (e.g. burning, bleeding or difficulty urinating)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (e.g. joint, muscle, back or neck pain)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (e.g. delayed healing, rash, acne, cellulitis, psoriasis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological (e.g. numbness, tingling, weakness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric (e.g. depression, anxiety, memory loss)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine (e.g. weight gain/loss, excess thirst or urination)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematologic (e.g. bruising, bleeding or clotting disorder)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic / Immunologic (e.g. rash, swelling, wheezing)	<input type="checkbox"/>	<input type="checkbox"/>	_____

PAST MEDICAL and FAMILY HISTORY:

Have you or a family member had problems with any of the following? Please indicate "Yes" with an "x" and indicate which family member.

DISEASE / CONDITION	Self	Family	Describe all "Yes" responses
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina / MI / Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Valve / Rhythm Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke / TIA / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma / COPD / Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
GERD / Ulcers / Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis / Liver / Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Failure / Stones / UTI / BPH	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis / Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding / Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia / Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid / Endocrine Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV / AIDS / TB	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psoriasis / Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

PAST SURGICAL HISTORY:

Procedure: _____ Surgeon _____ Date _____

Procedure: _____ Surgeon _____ Date _____

Procedure: _____ Surgeon _____ Date _____

Procedure: _____ Surgeon _____ Date _____

SURGICAL COMPLICATIONS: _____

ANESTHESIA: Have you ever had **problems with anesthesia?** yes no If yes, please describe: _____

SLEEP APNEA: Do you have Sleep Apnea? yes no Snore? yes no Stop breathing during sleep? yes no

MEDICATIONS (Prescription / Nonprescription / Herbal supplements / Vitamins / Other):			
Medication	Dosage	How Long?	Side Effects

ALLERGIES Please list type of allergy (medications, latex, food, etc.) and type of reaction you experience: _____

SOCIAL HISTORY:

Student yes no School _____ Grade _____ Sport _____

Tobacco use: yes no Packs per day: _____ Pipe? yes no Smokeless Tobacco? yes no
 Quit Years Smoked: _____

Alcohol use: never occasional daily heavy History of alcoholism? yes no History of drug use? yes no

Marital status: single married divorced widowed

Do you live alone? yes no If no, who do you live with? _____

Are you pregnant? yes no Breastfeeding? yes no Date of last menstrual period: _____

Comments or Clarification: _____

Patient/Guardian Statement:

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

_____/_____/_____
Patient Signature Date

_____/_____/_____
Guardian Signature Date

Guardian/Authorized Representative Printed Name

Provider Statement:

I have reviewed the questionnaire with the patient.

_____/_____/_____
Signed Date

_____/_____/_____
Signed Date

_____/_____/_____
Signed Date

_____/_____/_____
Signed Date