ORTHOPEDIC CENTER OF ILLINOIS

www.orthocenter.net
1301 S. Koke Mill Road
Springfield, IL 62711

HEALTH HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.)*:	☐ M ☐ F	**Acct#:**	
Date of Birth:	**Age:**	**Date:**	
Height:	**Weight:**	**Blood Pressure:**	**BMI:**
Phone #:	Work ___________________________	Home _____________________________	Cell ______________________________

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Children: Y / N Ages:	**Living Situation: Home, Nursing Home, Other**
Family/Primary Care doctor:	**Occupation:**
Doctor who referred you to OCI:	**Is this a work-related injury?:** ☐ Yes ☐ No
Preferred Pharmacy:	**Name of your employer:**

Reason for today's visit:

PERSONAL HEALTH HISTORY

Current/Chronic Medical Problems (i.e., Diabetes, Hypertension, High Cholesterol)

Illness	Illness

Past Surgeries

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Drug Name	Drug Name

Allergies to medications

Drug Name	Reaction You Had

ORTHOPEDIC CENTER OF ILLINOIS

www.orthocenter.net
1301 S. Koke Mill Road
Springfield, IL 62711

Patient Name:____Acct#:________________________

OTHER PROBLEMS

Check if you or a member of your immediate family have, or have had, any of the following problems.

You:	Mother:	Father:		You:	Mother:	Father:	
☐	☐	☐	High Blood Pressure	☐	☐	☐	Asthma
☐	☐	☐	Heart Attack	☐	☐	☐	COPD
☐	☐	☐	Stroke	☐	☐	☐	Emphysema
☐	☐	☐	Seizure	☐	☐	☐	HIV/AIDS
☐	☐	☐	Heart Disease	☐	☐	☐	Hepatitis (Type: ____________________)
☐	☐	☐	Pacemaker ID#____________________ Company Phone# ____________________	☐	☐	☐	Do you take blood thinners? Aspirin ___ Coumadin ___ Plavix ___
☐	☐	☐	Depression	☐	☐	☐	Liver Disease
☐	☐	☐	Anxiety	☐	☐	☐	Ulcer
☐	☐	☐	Kidney Disease	☐	☐	☐	GERD
☐	☐	☐	Thyroid Disease	☐	☐	☐	Anemia
☐	☐	☐	Diabetes (Type:________________________)	☐	☐	☐	Clotting problem/DVT/Pulmonary Embolus
☐	☐	☐	Cancer (Type: ________________________)	☐	☐	☐	Neuropathy
☐	☐	☐	History of MRSA or have had an infection that required isolation				
☐	☐	☐	Other:				

HEALTH HABITS AND PERSONAL SAFETY

Tobacco	Do you use tobacco? How much?	☐ Yes # of years:	☐ No Or year quit:
Imaging	Have you had X-rays, MRI, or CT for this problem? If yes, where:		
Pregnancy	Are you Pregnant?	☐ Yes	☐ No
Latex	Are you allergic to latex?	☐ Yes	☐ No
Ambulatory Aids	Do you use ambulatory aids? If so, What? ☐ Crutches ☐ Walker ☐ Cane ☐ Other:	☐ Yes	☐ No
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No

OFFICE USE ONLY

I certify that I have reviewed the above information. ____ M.D.