COOPER BONE & JOINT INSTITUTE
Patient History Form

DATE: / /

PATIENT NAME _____ AGE _____ DATE OF BIRTH: Month / Day / Year _____

OCCUPATION / STUDENT _____ **CURRENTLY WORKING**? ☐ Yes ☐ No SINCE: _____ Month / Day / Year

FAMILY OR PRIMARY DOCTOR _____ ( ) TELEPHONE NUMBER _____

WHO REFERRED YOU? PHYSICIAN OR ATC NAME _____ ( ) TELEPHONE NUMBER _____

ARE YOU AN ATHLETE? ☐ Yes **SPORT:** _____ ☐ No

☐ High school _____ ☐ College _____ ☐ Professional _____

HEIGHT _____ ft. _____ in. WEIGHT _____ lbs. ☐ Left Handed ☐ Right Handed

CHIEF COMPLAINT (Explain why you are here, include symptoms, body part, etc.) _____

IS THIS AN INJURY?: ☐ Yes ☐ No **DATE OCCURRED**: _____ **WORK RELATED**?: ☐ Yes ☐ No

ATTORNEY?: ☐ Yes ☐ No **NAME:** _____

IS THIS A CHRONIC PROBLEM?: ☐ **Yes** ☐ **No** **HOW LONG?:** _____

DESCRIBE IN DETAIL WHAT HAPPENED: _____

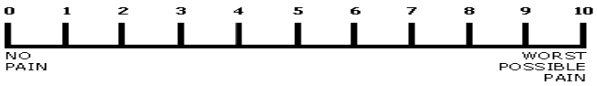
DOES INJURY OR COMPLAINT PREVENT YOU FROM WALKING? ☐ Yes ☐ No

If YES, how far can you walk without stopping? _____

DESCRIBE YOUR PAIN/LOCATION: _____

ARE YOU AFFECTED?: **USE PAIN SCALE TO RATE PAIN**:

☐ Morning _____ ☐ Day _____ ☐ Night _____



WHAT MAKES IT BETTER: _____ **WHAT MAKES IT WORSE:** _____

HAS THIS EVER BEEN INJURED BEFORE?: ☐ Yes ☐ No **If YES, who treated you?** _____

HAVE YOU HAD SURGERY TO THIS AREA? ☐ Yes ☐ No

If YES, when and the name of surgeon? _____

HAVE YOU HAD:	**WHEN, WHERE and LIST TYPE:**	**DID THIS HELP?:**
☐ X-RAYS	_____	
☐ MRI	_____	
☐ CAT SCAN	_____	
☐ ULTRASOUND	_____	
☐ PHYSICAL THERAPY	_____	☐ Yes ☐ No
☐ OCCUPATIONAL THERAPY	_____	☐ Yes ☐ No
☐ MEDICATIONS	_____	☐ Yes ☐ No
☐ INJECTIONS	_____	☐ Yes ☐ No
☐ BRACES	_____	☐ Yes ☐ No
☐ ORTHOTICS or SPECIAL SHOES	_____	☐ Yes ☐ No

PAST MEDICAL HISTORY:

PLEASE LIST/DESCRIBE PAST MEDICAL PROBLEMS:

_____

_____

_____

PLEASE LIST TYPE AND YEAR OF PREVIOUS SURGERIES:

_____ _____ _____ _____

_____ _____ _____ _____

WHAT MEDICATIONS DO YOU TAKE?

_____ _____ _____ _____

_____ _____ _____ _____

ARE YOU ALLERGIC TO:

☐ Medications _____

_____

_____

☐ Tape ☐ Iodine ☐ Latex

PLEASE DESCRIBE YOUR REACTION:

_____

_____

_____

DO YOU HAVE A FAMILY HISTORY OF:

☐ Heart Disease Mother ☐ Father ☐ Other _____

☐ Diabetes Mother ☐ Father ☐ Other _____

☐ Other illness _____ Mother ☐ Father ☐ Other _____

_____ Mother ☐ Father ☐ Other _____

Do you smoke? ☐ Yes ☐ No ☐ cigarettes ☐ cigar ☐ pipe? How many per day?_____ # of Years: ____

Have you quit? ☐ Yes ☐ No How long? _____

Do you drink alcohol? ☐ Yes ☐ No How often? _____

Do you use OTC/Herbal supplements? ☐ Yes ☐ No Type/Frequency _____

Do you use illegal substances? ☐ Yes ☐ No Type/Frequency _____

REVIEW OF SYSTEMS: (PLEASE CHECK ANY HEALTH PROBLEMS IN THE FOLLOWING AREAS)

HEART	**MUSCULOSKELETAL**	**RESPIRATORY**	**ENDOCRINE**
☐ Coronary Artery Disease	☐ Osteoarthritis	☐ Asthma	☐ Thyroid Disease
☐ Hypertension	☐ Osteoporosis	☐ Emphysema	☐ Diabetes 1 or 2
☐ High Cholesterol	☐ Chronic Muscle Pain	☐ Sleep Apnea	☐ Excessive Weight Loss
☐ Heart Murmur	☐ Swollen Joints	☐ Shortness of Breath	☐ Excessive Weight Gain
☐ Other	☐ Other	☐ Other	☐ Other
NEURO	**VASCULAR**	**HEENT**	**URINARY**
☐ Numbness	☐ Phlebitis	☐ Blurry Vision	☐ Frequent ☐ Burning
☐ Seizure Disorder	☐ Clotting / Bleeding Problems	☐ Hearing Loss ☐ Ringing in Ears	☐ Blood in Urine
☐ Tremors ☐ Stroke	☐ Easy Bruising	☐ Pain with Swallowing	☐ Kidney Stone
☐ Other	☐ Other	☐ Other	☐ Other
SKIN	**GASTROINTESTINAL**	**PSYCHIATRIC**	**GENERAL**
☐ Rash ☐ Psoriasis	☐ Reflux ☐ Peptic Ulcer	☐ Anxiety ☐ Depression	☐ Cancer _____
☐ Lesions ☐ Moles	☐ Hepatitis ☐ Gallstones	☐ Schizophrenia ☐ ADHD	☐ Fever ☐ Chills
☐ Other	☐ Other	☐ Other	☐ Night sweats ☐ HIV
			☐ Other_____
GENITALS / BREAST			_____
☐ Tumor ☐ Erectile Dysfunction ☐ Large Prostate ☐ Nipple Discharge			
☐ Menopause ☐ LMP _____ Other			

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____