

**Louisville Bone & Joint Specialists, PSC
Patient Medical History Sheet**

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Patient Name: _____ **Today's Date:** _____

Patient Date of Birth: _____ **Age:** _____ **Patient Account # (office use only)** _____

Please answer the following questions completely:

Who is your PCP or Family Doctor? _____

ARE YOU PREGNANT OR IS THERE A CHANCE YOU MIGHT BE? **YES** **NO**

What part of your body are we seeing you for today? _____ Right Left Both

Did you have an injury? **Yes** **No** If yes, date of injury _____ (required by insurance)

If no injury, how long have you had pain? _____ Days _____ Months _____ Years

Please describe how you were injured and/or where your pain is: _____

Have you seen another doctor for this problem? **Yes** **No** If yes, who? _____

Have you had x-rays or tests for this problem? **Yes** **No** If yes, where? _____

Did you bring your x-rays or tests with you today? **Yes** **No**

Is your condition related to: **Work** **Car Accident** **Other** _____

What is your occupation? _____ Are you **Right** or **Left** handed?

Is there a lawsuit pending in this case? **Yes** **No**

Were you referred here by a physician? **Yes** **No** If yes, name of referring physician: _____

How much do you smoke _____ **packs/day for** _____ **years** **OR** **None**

How much alcohol do you drink _____ **drinks/week** **OR** **None**

Single Married Widowed Divorced Spouse Name: _____

Have you ever been diagnosed with any of the following medical conditions?

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Asthma			Diabetes			Sleep Apnea		
Lupus			Osteoarthritis			Sickle Cell Disease		
Goiter			High Blood Pressure			Kidney Disease		
Colitis			Rheumatoid Arthritis			Cardiac Disease		
Seizures			DVT-Blood Clots			Stomach Ulcers		
Cancer			Hepatitis			Depression/Anxiety		
Stroke			Tuberculosis			Bleeding Tendencies		
Anemia			COPD			Other _____		

Are you currently being treated for osteoporosis? **Yes** **No** When was your last DEXA Scan or bone density test?

Have you ever been treated for **MRSA**? **Yes** **NO** **When?** _____

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Please list any other medical problems you have: _____

Has anyone in your family had: High Blood Pressure Diabetes Heart Disease Lung Disease
 DVT-Blood Clots Bleeding Problems Cancer - Type: _____

Please list all surgical procedures:

Orthopaedic Surgeries	Date		Other Surgeries	Date

Are you allergic to _____LATEX _____BETADINE _____IODINE _____NUMBING MEDICINES

Please list all medications that you take, including ALL over the counter medicines (vitamins, supplements, diet aids, etc.):

Medication	Dosage		Medication	Dosage

PLEASE LIST ALL MEDICINE ALLERGIES:

Please provide the name and phone number of your pharmacy:

Please continue to next page

