

# ARIZONA IBJD Medical History

|       |  |              |  |
|-------|--|--------------|--|
| Name: |  | Account #:   |  |
| Date: |  | Referred By: |  |

## CHIEF COMPLAINT

|  |                                       |  |                                |
|--|---------------------------------------|--|--------------------------------|
| Why are you here today?  |                                       |  |                                |
|  |                                       |  |                                |
|  |                                       |  |                                |
| Which side is involved? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both |                                       |  |                                |
| What makes it better?  |                                       |  |                                |
|  |                                       |  |                                |
| What makes it worse?   |                                       |  |                                |
|  |                                       |  |                                |
| Your problem is the result of an: (Check all that apply)?  |                                       |  |                                |
| <input type="checkbox"/> Accident  | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Work Accident | <input type="checkbox"/> Other |
|  |                                       |  |                                |

## MEDICATIONS INCLUDING ALL VITAMINS, MINERALS & HERBS

|    | Medication | Dose/Frequency | How Long Taking? | Side Effects |
|----|------------|----------------|------------------|--------------|
| 1. |            |                |                  |              |
| 2. |            |                |                  |              |
| 3. |            |                |                  |              |
| 4. |            |                |                  |              |
| 5. |            |                |                  |              |
| 6. |            |                |                  |              |
| 7. |            |                |                  |              |
| 8. |            |                |                  |              |
| 9. |            |                |                  |              |

## ALLERGIES

|   |                                  |                                |                                     |                                 |                                |   |
|---|----------------------------------|--------------------------------|-------------------------------------|---------------------------------|--------------------------------|---|
| Are you allergic to any of the following? (Check all that apply)  |                                  |                                |                                     |                                 |                                |   |
| <input type="checkbox"/> Aspirin  | <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Keflex | <input type="checkbox"/> Latex | <input type="checkbox"/> Steroid injections |
| Other allergies:  |                                  |                                |                                     |                                 |                                |   |
| Serious side effects?   |                                  |                                |                                     |                                 |                                |   |
|   |                                  |                                |                                     |                                 |                                |   |
| For Women: Are you taking birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                  |                                |                                     |                                 |                                |   |
| Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Week#:                       |                                  |                                |                                     |                                 |                                |   |

## VITALS

|      |         |         |
|------|---------|---------|
| Age: | Height: | Weight: |
|------|---------|---------|

|            |       |
|------------|-------|
| Signature: | Date: |
|------------|-------|

|       |  |            |  |
|-------|--|------------|--|
| Name: |  | Account #: |  |
|-------|--|------------|--|

| SURGERIES / HOSPITALIZATIONS          |                 |  |                |
|---------------------------------------|-----------------|--|----------------|
|                                       | Type of Surgery | Year   | Complications? |
| 1.                                    |                 |  |                |
| 2.                                    |                 |  |                |
| 3.                                    |                 |  |                |
| 4.                                    |                 |  |                |
| 5.                                    |                 |  |                |
| Have you ever had general anesthesia? |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |                |
| Have any problems with anesthesia?    |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |                |

| REVIEW OF SYSTEMS  |  |
|--|--|
| Check or circle all of the following diseases or medical problems that you have had at any time? |  |
| <input type="checkbox"/> High / Low Blood Pressure   | <input type="checkbox"/> Shortness of Breath                   |
| <input type="checkbox"/> Anemia / Transfusions   | <input type="checkbox"/> Epilepsy / Seizures / Fainting Spells |
| <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Heart Attack / Heart Bypass Surgery   |
| <input type="checkbox"/> Blood Clots / Pulmonary Embolus   | <input type="checkbox"/> Pacemaker                             |
| <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Heart Murmur / Congenital defect      |
| <input type="checkbox"/> HIV / AIDS  | <input type="checkbox"/> Mitral valve prolapse                 |
| <input type="checkbox"/> Hemophilia / Abnormal Bleeding  | <input type="checkbox"/> Bladder Problems / Kidney Problems    |
| <input type="checkbox"/> Rheumatoid Arthritis  | <input type="checkbox"/> Bowel Problems                        |
| <input type="checkbox"/> Artificial bone or joints   | <input type="checkbox"/> Diabetes                              |
| <input type="checkbox"/> Bone infections   | <input type="checkbox"/> Polio                                 |
| <input type="checkbox"/> Eyes  | <input type="checkbox"/> Low back pain / sciatica              |
| <input type="checkbox"/> Ears / Nose / Throat  | <input type="checkbox"/> Drug / Alcohol Abuse                  |
| <input type="checkbox"/> Stomach / Digestion   | <input type="checkbox"/> Psychiatric Problems                  |
| <input type="checkbox"/> Thyroid   | <input type="checkbox"/>                                       |
| <input type="checkbox"/> Asthma / Trouble Breathing  | <input type="checkbox"/>                                       |
| Describe any additional medical information that you feel we need to know:                       |  |
|  |  |

| SOCIAL HISTORY                    |  |  |                                     |                                     |  |
|-----------------------------------|--|--|-------------------------------------|-------------------------------------|--|
| Occupation:                       |  | Employed By:                           |                                     |                                     |  |
| Work Status:                      | <input type="checkbox"/> Full Time                       | <input type="checkbox"/> Part Time     | <input type="checkbox"/> Restricted |                                     |  |
| <input type="checkbox"/> Disabled | <input type="checkbox"/> Retired                         | <input type="checkbox"/> Work At Home  | <input type="checkbox"/> Student    |                                     |  |
| Marital Status:                   | <input type="checkbox"/> Single                          | <input type="checkbox"/> Married       | <input type="checkbox"/> Divorced   | <input type="checkbox"/> Separated  | <input type="checkbox"/> Widowed                         |
| Children:                         | <input type="checkbox"/> No                              | <input type="checkbox"/> Yes           | How Many?                           | Do you live alone?                  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Exercise?                         | <input type="checkbox"/> Daily                           | <input type="checkbox"/> Weekly        | <input type="checkbox"/> Rarely     | <input type="checkbox"/> Never      |  |
| What type of exercise?            |  |  |                                     |                                     |  |
| Are you on a special diet?        | <input type="checkbox"/> No <input type="checkbox"/> Yes | Describe:                              |                                     |                                     |  |
| History of substance abuse?       | <input type="checkbox"/> No <input type="checkbox"/> Yes | Describe:                              |                                     |                                     |  |
| Smoke currently?                  | <input type="checkbox"/> No <input type="checkbox"/> Yes | Packs per day for _____ years.         |                                     |                                     |  |
| Quit smoking?                     | <input type="checkbox"/> This year                       | <input type="checkbox"/> > 1 year      | <input type="checkbox"/> > 5 years  | <input type="checkbox"/> > 10 years |  |
| Previously smoked                 | Packs per day for _____ years.                           |  |                                     |                                     |  |
| Drink alcohol?                    | <input type="checkbox"/> Daily                           | <input type="checkbox"/> 1-2x per week | <input type="checkbox"/> Never      | <input type="checkbox"/> How much?  |  |