REASON FOR VISIT
BLOOMINGTON BONE AND JOINT CLINIC, P.C.

Today's Date: _____
Name (Last, First, MI) _____ Age: _____

Doctor being seen today: _____ Doster, M.D. _____ Fox, M.D. _____ Dellacqua, M.D.
_____ Pannunzio, M.D. _____ Meyers, M.D. _____ Weidenbener, M.D

Referring Doctor: _____ Address: _____
Family Doctor: _____ Address: _____

Is Patient's Condition Related to: Employment (current or previous) Y / N Auto Accident Y/ N Other Accident Y/ N

What kind of problem are you having: Body Part: _____Left _____ Right _____ Both _____

What date did this begin: _____ How did this problem begin? _____

Where did the accident take place: _____ Were x-rays taken Y / N Date of x-rays _____

Where were they taken? Bloomington Hospital _____ SIRA _____ IU Health Center_____ Monroe Hospital _____ Promptcare East _____ Other (Please name) _____

MEDICAL HISTORY

Current Medications & Dosage **Medical Allergies Y / N**

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Do you, or have you ever had, diseases or conditions, surgeries or hospitalization of (please circle and list date).

Diabetes _____ High Blood Pressure _____ Angina/Chest Pain _____ Heart Failure _____
Heart Attack _____ Heart Rhythm Disorder _____ Blood Clots _____ Tuberculosis _____
Asthma _____ Other Lung Disorders _____ Ulcers _____ Hepatitis _____ Cancer _____
Kidney Disorder _____ Mental Disorder _____ Stroke _____ Tonsillectomy _____
Appendectomy _____ Gall Bladder _____ Hysterectomy _____ Hernia _____
Heart Surgery _____ Spinal Surgery _____HIV/AIDS _____

Please list any Trauma/ injury/ previous fracture dates: _____

Do you have any artificial joint(s) Y / N, If yes, where: _____

Please list any other diseases, conditions, surgeries or hospitalizations not listed in the above list: _____
_____
Is there family history of significant medical problems? Y / N, if yes, please explain: _____
_____
Alcohol Use: Y / N. If yes, # drinks per day: _____ Tobacco use: Y / N. If yes, # of packs per day _____

Reviewed and discussed with patient by Doctor. Physician Signature _____ Date: _____