

**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: \_\_\_\_\_

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**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) \_\_\_\_\_

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**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: \_\_\_\_\_