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JUNEAU BONE AND JOINT CENTER

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Dr. Bursell's Health History

Please note that this form should be updated every six months to ensure proper diagnosis and treatment options

Patient Name:_____ Date:_____

Date of Birth:_____ Occupation:_____ Height:_____ Weight:_____

Primary Care Provider:_____ Facility of Primary Care Provider:_____

Reason for visit:_____

When did your pain start?_____

Has your pain increased recently? □Yes □No, How recently? _____

Is your pain related to a recent injury? □Yes □No, Please describe:_____

Did you notice any of the following at the time of injury? □ A "pop" □Tearing sensation □Swelling

Which of the following best describes your pain? (Select all that apply)

□Dull □Sharp □Aching □Burning □Numbness □Tingling

How often does your pain occur? □Constantly □Intermittently □Awakens me from sleep

What aggravates your symptoms?_____

What improves your symptoms?_____

Do you have difficulty picking up small objects such as coins or buttons? □Yes □No

Do you have a problem with balance or tripping? □Yes □No

Have you had an recent falls? □Yes □No, How many? _____

There are (□Frequent □Occasional □No) headaches in the back of the head

The pain is present the most while: □Standing □Sitting □Walking □Lying Down

How many minutes can you stand in one place without pain? □0-10 □15-30 □30-60 □60+

How many minutes can you sit in one place without pain? □0-10 □15-30 □30-60 □60+How many minutes can you walk without pain? □0-10 □15-30 □30-60 □60+

Lying down: □Increases the pain □Decreases the pain □Does not affect the pain

Bending over: □Increases the pain □Decreases the pain □Does not affect the pain

Current Medications: Please list medications you are currently taking, including non-prescription drugs and dosages □ **None**

1.	5.
2.	6.
3.	7.
4.	8.

Drug Allergies: Please list any allergies, if there are none known, then mark the box next to none. ☐ **None**

Medication:	Reaction:

Past Surgical History: ☐**None**

Type:	Year:	Type:	Year:
Heart Bypass ☐ Pacemaker ☐ Heart Valve ☐ Heart Stent ☐ Cancer Surgery ☐ Prostate Surgery ☐	_____ _____ _____ _____ _____ _____	Spine Surgery ☐Cervical ☐Thoracic☐ Lumbar Hip Surgery ☐Right ☐Left ☐Both Knee Surgery ☐Right ☐Left ☐Both Shoulder Surgery ☐Right ☐Left ☐Both	_____ _____ _____ _____

Other Surgeries:_____ Year:_____

_____ Year:_____

Prior Treatment: ☐**None**

☐Physical Therapy ☐Oral Steroids ☐Cortisone Injections ☐Surgery☐Medications

☐Other:_____

Prior Diagnostics: ☐**None**

☐X-Ray ☐MRI ☐CT ☐EMG (Nerve Conduction Study)

☐Other:_____

Medical History: Please select all that apply ☐**None**

☐ AIDS /HIV	☐ Chemical Dependency	☐ High Blood Pressure	☐ Psychiatric Care
☐ Alcoholism	☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Emphysema	☐ Liver Disease	☐ Stroke
☐ Arthritis	☐ Epilepsy	☐ Multiple Sclerosis	☐ Suicide Attempt
☐ Asthma	☐ Gout	☐ Pacemaker	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Heart Disease	☐ Pneumonia	☐ Tuberculosis
☐ Bronchitis - chronic	☐ Hepatitis	☐ Polio	☐ Ulcers
☐ Cancer	☐ Herpes	☐ Prostate Problem	

☐Other:_____

Social History: How often do you use any of the following substances? ☐**None**

Caffeine: ☐Frequently ☐Occasionally ☐Never

Drugs: ☐Frequently ☐Occasionally ☐Never ☐Narcotics ☐Recreational ☐Other:_____

Tobacco: ☐Frequently ☐Occasionally ☐Never

Marijuana: ☐Frequently ☐Occasionally ☐Never

Alcohol: ☐Frequently ☐Occasionally ☐Never _____drinks per week

Cigarettes: ☐Frequently ☐Occasionally ☐Never _____ packs per day

Review of Symptoms: ☐None

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Gastrointestinal
- ☐ Poor appetite
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Nausea
- ☐ Stomach pain

Eye, Ear, Nose, Throat
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

Muscle, Joint, Bone (pain, weakness, numb)
- ☐ Arm
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Skin
- ☐ Bruise easily
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

Family History:

Relation	Age	Current state of health	Age at death	Cause of death	Check if your blood relatives had any of the following:	
Father					☐ Arthritis	
Mother					☐ Gout	
Brothers					☐ Cancer	
					☐ Diabetes	
					☐ Heart Disease	
Sisters					☐ High Blood Pressure	
					☐ Rheumatoid Arthritis	
					☐ Stroke	
					☐ Other	

_____ Patient Signature

_____ Date