John Bursell, MD
Gustavo Garcia, MD

JUNEAU BONE AND JOINT CENTER

Daniel Harrah, MD
Meghan Lindquist, PA-C

Health History

Name_____ Occupation _____Today's Date_____
Date of Birth _____ Age _____ Date of Injury _____

Family Doctor & Clinic _____
What condition are you seeing the doctor for today? _____

_____

Have you seen any other doctor for this condition? ☐ No ☐ Yes, please name _____

Past Medical History Conditions: Check (X) any conditions that you currently have or have had in the past:

☐ AIDS/HIV Positive	☐ 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_____

Surgeries/Hospitalizations: ☐ None

Year:	Operation/Procedure:	Hospital:

Non-Surgical Procedures: ☐ None

Year:	Procedure:	Hospital:

Have you ever had a blood transfusion? ☐ No ☐ Yes, approximate date _____

Medication: List medications you are currently taking, including non-prescription drugs and dosages ☐ None

**** Please complete the backside of this form ****

Health History

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

_____ _____ _____

_____ _____ _____

Social History: Check (X) which substances you use and describe how much you use and how frequently ☐ None

☐ Alcohol ☐ Caffeine ☐ Drugs ☐ Tobacco ☐ Other

_____ _____ _____ _____ _____

Family History:

Relation	Age	Current state of health	Age at death	Cause of death	Check (X) 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	

Symptoms: Check (X) symptoms you currently have or have had in the past year. ☐ 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

_____ _____

Patient Signature Date