BONE AND JOINT SPECIALISTS OF CHESTERFIELD, LLC
ANDREW J. BLACKMAN MD

Name: _____ Date of Birth: _____

Height:_____ Weight:_____

How did you hear about our office? _____

Name of referring physician (if applicable): _____

PAST MEDICAL HISTORY:

Please list any medical problems that you have been diagnosed with by a medical professional.
(For example, high blood pressure, diabetes, etc.)

PROBLEM	**YEAR OF DIAGNOSIS**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST SURGICAL HISTORY:	**YEAR OF SURGERY**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS:

Name of Medication Dosage Frequency

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you allergic to any medications? YES ☐ NO ☐

If yes, please list the medication and the type of reaction you had.

_____
_____
_____
_____

BONE AND JOINT SPECIALISTS OF CHESTERFIELD, LLC
ANDREW J. BLACKMAN MD

Do you have other allergies? YES ☐ NO ☐

If yes, please list:

_____

_____

FAMILY HISTORY:

Do you have a family history of any of the following?

If yes, please indicate the relationship (Mother, Father, or Siblings)

Diabetes	YES ☐ NO ☐	_____
Hyptension	YES ☐ NO ☐	_____
Heart Disease	YES ☐ NO ☐	_____
Stroke	YES ☐ NO ☐	_____
Mental Illness	YES ☐ NO ☐	_____
Cancer	YES ☐ NO ☐	_____

SOCIAL HISTORY:

Do you smoke? YES ☐ NO ☐

Do you consume alcohol? YES ☐ NO ☐

FALL RISK ASSESSMENT (If 65 or older)

In the past year, have you had:

☐ No falls

☐ One fall with injury

☐ Two or more falls with injury

☐ One fall without injury

☐ Two falls without injury

HEALTH MAINTENANCE (IF AGE APPROPRIATE)

	Date Performed
Colonoscopy (50-75)	_____
Mammogram (40-69)	_____
Flu Administration (6 months +)	_____
Pneumonia Immunization (65+)	_____

Patient Signature: _____ Date: _____

Review of Systems

Please check any of the following symptoms you are currently experiencing or have recently experienced:

GENERAL:

- ☐ Unexplained weight loss
- ☐ Fevers or chills

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Syncopal episodes

GASTROINTESTINAL

- ☐ Bloody stools
- ☐ Diarrhea
- ☐ Vomiting

NEUROLOGIC

- ☐ Seizures
- ☐ Numbness in hands or feet

SKIN:

- ☐ Nonhealing wounds
- ☐ Rash

RESPIRATORY

- ☐ Painful breathing
- ☐ Difficulty breathing

ALLERGIC

- ☐ Latex sensitivity
- ☐ Iodine sensitivity

HEMATOLOGIC:

- ☐ Blood clot
- ☐ Bleeding disorder
- ☐ Sickle cell disease

ENT:

- ☐ Poor dental health
- ☐ Difficult airway

PSYCHIATRIC

- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal thoughts