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Name _____ Age _____ Height _____ Weight _____ R/L hand _____

General Questions:

Reason for consultation _____

Duration of problem _____

Who is your family physician? _____

Who referred you to this office? _____

Have you seen other doctors for this problem? _____

Have you had any tests or x-rays done previously? _____

List any medicines you are taking _____

List any medicines you are allergic/react abnormally to _____

List any allergies _____

List any operations you have had and when _____

Have you had any anesthetic complications? _____

Do you take aspirin or blood thinners? _____

Is there a chance you could be pregnant? _____

Approximate date of last menstrual period _____

Do you smoke? _____ If yes, how much? _____

Social History

What is your Occupation? _____

List any occupational hazards you are exposed to _____

Are your parents living? _____ If not, cause of death _____

Are your siblings living? _____ If not, cause of death _____

List any history of cancer in your family _____

HAVEN TOLD YOU HAVE ANY OF THE FOLLOWING CONDITIONS

PATIENT SIGNATURE _____ DATE _____

	YES	NO
Heart disease		
Heart attack		
Chest pain		
Abnormal EKG		
Irregular pulse		
High blood pressure		
Shortness of breath		
Asthma		
Bronchitis		
Pneumonia		
Tuberculosis		
Emphysema		
Smoker's cough		
Coughing up blood		
Nervous breakdown		
Nervous disorder		
Stroke or Mini stroke		
Palsy/Paralysis		
Thyroid problem/ Goiter		
Epilepsy		
Kidney disorder		
Blood clots/DVT		
Headaches		
Diabetes		

	YES	NO
Skin disorders		
Drug abuse		
Hepatitis		
Yellow jaundice		
Cirrhosis		
Alcoholism		
Gallbladder/Gallstones		
Indigestion		
Ulcers		
Colitis		
Bladder problems		
Vomiting blood		
Blood in bowel/stool		
Hemorrhoids		
Visual disturbance		
Glaucoma		
Back problems/fracture		
Arthritis		
Bleeding tendency		
Blood transfusion		
Bleeding after tooth pulling		
Cancer		
Airway obstruction		
HIV		
AIDS		
Metal Allergy		