LAWRENCE LI, MD
ORTHOPEDIC & SHOULDER CENTER
Minimum Invasion • Maximum Result

2200 Ft Jesse Rd, Suite 250
Normal, IL 61761
Phone: 309-888-9800
Fax: 866-888-9198

Medical History Form

Account Number _____ Visit Date _____ Staff Initials _____

Patient Information

Name	Date of Birth	Height	Weight

Medical Conditions

Please check if you have a history of the following:

Asthma _____	Insulin Diabetes ☐ Non-Insulin Diabetes ☐	Emphysema ☐	Urinary Tract Infection _____	Arthritis _____	Gout ☐	HyperThyroid ☐ HypoThyroid ☐
Hypertension (High Blood Pressure) _____			Cancer (please specify) _____			
Do you use recreational drugs? Yes _____ No _____			If yes please specify _____			
Do you Smoke Tobacco? Yes _____ No _____			Do you drink alcohol regularly? Yes _____ No _____			

Please list any medical conditions you may have other than the ones states above: _____

Please list all surgeries you have had: _____

Medications

Please list all medications, including over-the counter and herbals, with dosages, schedules, and reasons for currently taking them:

Please list all allergies to MEDICATIONS and your reaction below	Are you allergic to Latex? Yes _____ No _____

Previous Treatments

Have you had any of the following Medical or Rehabilitative services for the ***INJURY WE ARE SEEING YOU FOR TODAY.***

Xray _____	MRI _____	EMG/NCV _____	CT Scan ☐	Physical Therapy _____	Occupational Therapy ☐

If yes to any, please list when and where the procedure was performed: _____

IF YOU HAVE A LIST OF YOUR MEDICATIONS, PLEASE ASK THE RECEPTIONIST TO MAKE A COPY