John C. Kefalas, M.D., FAAOS
Board Certified in Orthopedic Surgery

P: 217-425-2600
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www.cibjc.com

MEDICATION LIST

(This includes vitamins, supplements, and all over the counter medicines including anti-inflammatories)

This list must be completed in its entirety for every visit. If you have a medication list you may provide that in place of filling out the form

Patient Name: _____ Date of Birth:_____ Date:_____

DRUG NAME	DOSE/MG	FREQUENCY

DRUG ALLERGIES

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Name_____ Date of birth_____ Age_____

Male or Female Height_____ Weight_____ Hand Dominance Right or Left

Reason for today's visit: _____

Medical History, Please circle Yes or No. If yes, please explain.

YOURSELF		IMMEDIATE FAMILY MEMBERS
NO YES	Arthritis	NO YES
NO YES	Back Disorder	NO YES
NO YES	Cancer	NO YES
NO YES	Diabetes	NO YES
NO YES	Epilepsy	NO YES
NO YES	Stomach problems	NO YES
NO YES	Gout	NO YES
NO YES	High blood pressure	NO YES
NO YES	Heart condition	NO YES
NO YES	Blood disorder	NO YES
NO YES	Blood Clots	NO YES
NO YES	Lung Disease	NO YES
NO YES	History of MRSA	
NO YES(IF YES, WHEN)	Covid-19	

PAST SURGERIES DESCRPTION YEAR

_____

_____

_____

_____

SOCIAL HISTORY PLEASE CIRCLE AND LIST HOW MUCH

Tobacco/Vape NO YES_____ Alcohol NO YES_____

Marijuana NO YES_____ Cocaine NO YES_____

Other NO YES_____

Signature_____ Date_____

Please circle yes if you have had any of the following conditions. Circle no if you have not had any of the following symptoms or conditions.

Head and Nerves

Frequent or severe headaches	Yes	No
Dizziness or loss of balance	Yes	No
Fainting	Yes	No
Seizures	Yes	No
Stroke	Yes	No
Weakness of arms or legs	Yes	No
Numbness of arms and legs	Yes	No

Eyes

Decreased vision	Yes	No
Double vision	Yes	No
Dry eyes	Yes	No
Eye pain	Yes	No
Eye redness	Yes	No

Ears, Nose, Throat

Decreased hearing	Yes	No
Noises in ear(s)	Yes	No
Nose bleeds	Yes	No
Stuffy nose	Yes	No
Frequent sore throat	Yes	No
Hoarseness	Yes	No
Difficulty swallowing	Yes	No

Breathing and Lungs

Frequent cough	Yes	No
Frequent cold	Yes	No
Hay fever	Yes	No
Asthma	Yes	No
Chronic bronchitis	Yes	No
Emphysema	Yes	No
Shortness of breath	Yes	No

Heart/Blood vessels

Chest pain	Yes	No
Heart disease	Yes	No
High blood pressure	Yes	No
Anemia	Yes	No
Blood Clots	Yes	No
Bruise easily	Yes	No
Swelling of the ankles and feet	Yes	No

Stomach and Intestines

Heart burn	Yes	No
Frequent nausea	Yes	No
Vomiting	Yes	No
Ulcer	Yes	No
Liver problems	Yes	No
Gallbladder disease	Yes	No
Frequent diarrhea	Yes	No
Frequent constipation	Yes	No
Hemorrhoids	Yes	No

Stomach and intestines continued

Bloody or tarry stool	Yes	No
Loss of bowel control	Yes	No
Hernia	Yes	No

Muscle and Bones

Spine abnormality	Yes	No
Joint pain and stiffness	Yes	No
Tendonitis or bursitis	Yes	No
Muscle wasting	Yes	No
Broken bones	Yes	No

Urinary

Kidney stones	Yes	No
Blood in urine	Yes	No
Painful urination	Yes	No
Frequent urination	Yes	No
Difficulty urinating	Yes	No
Urinary tract infection	Yes	No
Loss of urinary control	Yes	No

Glands

Diabetes	Yes	No
Thyroid problems	Yes	No

Skin

Rash	Yes	No
Psoriasis	Yes	No
Eczema	Yes	No
Dermatitis	Yes	No

Emotional

Physical, sexual, emotional abuse	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Difficulty sleeping	Yes	No
Frequent nightmare	Yes	No
Irritability	Yes	No

General

Fatigue	Yes	No
Fever	Yes	No
Weight gain	Yes	No
Weight loss	Yes	No
Loss of appetite	Yes	No

Print Name: _____

Signature: _____

Date: _____