

PLEASE PRINT USING BLACK OR BLUE PEN ONLY

Patient's Name: (Last) (First) (M.I.)

Patient's Age: ____ Years Date of Birth: ____/____/____ Height: (Ft) ____ (In) ____ Weight: ____

This form is being completed by: Patient Spouse Parent Guardian Other

Who is your Medical Doctor or Primary Care Physician?

Name: _____
First Last

Address: _____

City: _____ State: _____

Who referred you to Hinsdale Orthopaedics? _____

Referring Physician: _____

Occupation:

How long have you been doing this work?

HISTORY OF PRESENT ILLNESS (HPI) / REASON FOR VISIT:

I have brought outside films: X-Ray MRI None

Which is your dominant hand? Right Left

Reason for visit today: _____ Right Extremity Left Extremity
(Example: wrist, ankle, low back)

Approximate date of the onset of the present problem: _____

How did the problem occur? _____

Any previous problems to this area? No Yes If yes, describe: _____

1. Who have you seen for this problem? _____
(Emergency room, family physician, etc.)

2. Have you had any past test within the last year that pertains to your visit today? No Yes

Which tests? MRI EMG Bone Density (DEXA) CT Scan X-RAY Other

What treatments have you had? Physical Therapy Exercises Injections Other

3. Intensity of pain (circle one): None 1 2 3 4 5 6 7 8 9 10 Severe

4. Timing of pain/problem: _____
(When symptoms occur; example: after meals, exercise, etc.)

5. Duration of pain/problem: _____
(How long have you had symptom/pain? weeks, months, years?)

6. Type of pain: Burning Aching Stabbing Sharp Shooting Deep Other

7. Does the pain radiate? No Yes To where? _____

8. What measures relieve the pain? _____

9. What makes the pain worse? _____

REASON FOR VISIT CONTINUED:

Did your injury occur at: Work Motor Vehicle Accident Home Sports Related Other

If Injury occurred at work:

Job Title: _____

Employer Name: _____

Address: _____ Phone: _____

Type of work Performed: _____

Have you filed an injury report with your employer? No Yes

YOUR PERSONAL MEDICAL HISTORY

	NO	YES		NO	YES		NO	YES
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack / Disease	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, or C	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Control Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots (DVT)	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Coagulation Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Lupus Erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	Steroid Use	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Lyme	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>						

Any other medical problems not listed? _____

Have you had a DEXA (Hip & Spine) for bone density before? No Yes When? _____

Have you or any relatives had problems with anesthesia? No Yes

Do you have any implants (pins, rods, screws, etc.)? No Yes

If so, where are they? _____

PAST SURGICAL/HOSPITALIZATION HISTORY		
Year	Hospital/Location	Reason

Have you ever had any problems with Anesthesia? No Yes

ALLERGIES <input type="checkbox"/> No Allergies <i>List any allergies you have and what type of allergic reaction you experience</i>				
Latex Allergy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Allergic to:	Reaction:
Metal Allergy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Allergic to:	Reaction:
Medication Allergy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Allergic to:	Reaction:
Other Allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Allergic to:	Reaction:

MEDICATION HISTORY <i>Please include prescription drugs, and drugs you buy over the counter</i>			
Medication	Dose/Strength	When do you take it?	Reason you take the medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

PREFERRED PHARMACY

Pharmacy: _____

Address: _____ Phone: _____

SOCIAL HISTORY

Marital status: Married Single Widowed Divorced Separated Significant Other

Smoking:

- Has never smoked Former smoker Exposure to passive smoke
- Currently smokes Has been advised to quit No exposure to passive smoke

No. of packs per day _____

Alcohol:

- Drinks alcohol No. of Drinks per day _____ Does not drink alcohol

SOCIAL HISTORY

Drugs:

Are you taking any unprescribed drugs, including recreational drugs? No Yes

If yes, please specify: _____

Exercise:

Exercises regularly Does not exercise regularly

Residence: Is patient currently residing at a Nursing / Rehab facility? No Yes

If yes, name and address of facility: _____

OBSTETRICAL HISTORY (FOR FEMALES ONLY)

Are you currently pregnant? NO YES No. of Children _____ No. of Pregnancies _____ No. of Deliveries _____

YOUR FAMILY MEDICAL HISTORY (PARENTS, SIBLINGS AND OTHER RELATIVES)

	Father	Mother	Sibling	Other		Father	Mother	Sibling	Other		Father	Mother	Sibling	Other
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack / Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary Embolism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Control Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, or C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots (DVT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coagulation Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Steroid Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If other please list whom: _____

Any other medical problems not listed? _____

REVIEW OF SYSTEMS (ROS) <i>Please indicate which, if any, of the following problems you have by circling YES or NO</i>								
Constitutional			Ears/Nose/Mouth/Throat			Eyes		
Good general health	Yes	No	Hearing loss or ringing	Yes	No	Wear glasses/contacts	Yes	No
Recent weight change	Yes	No	Sinus problems	Yes	No	Blurred/double vision	Yes	No
Night sweats, fevers	Yes	No	Nose bleeds	Yes	No	Eye disease or injury	Yes	No
Fatigue	Yes	No	Sore throat/voice change	Yes	No			
Cardiovascular			Respiratory			Gastrointestinal		
Chest pain	Yes	No	Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Palpitations	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart trouble	Yes	No	Coughing up blood	Yes	No	Rectal bleeding	Yes	No
Swelling hands/feet	Yes	No				Bowel problems	Yes	No
Musculoskeletal			Neurological			Integumentary (Skin/Breast)		
Muscle pain or cramps	Yes	No	Frequent headaches	Yes	No	Change in hair or nails	Yes	No
Stiffness/swelling joints	Yes	No	Paralysis or tremors	Yes	No	Rashes or itching	Yes	No
Joint pain	Yes	No	Numbness/tingling	Yes	No	Breast lump	Yes	No
Trouble walking	Yes	No				Breast pain or discharge	Yes	No
Endocrine			Hematologic/Lymphatic			Allergic/Immunologic		
Excessive thirst/urination	Yes	No	Bruise easily	Yes	No	Food allergies	Yes	No
Hormone problem	Yes	No	Slow to heal	Yes	No	Aspirin allergies	Yes	No
			Enlarged glands	Yes	No	Antibiotic allergies	Yes	No
Genitourinary - Male Only			Genitourinary - Female Only			Psychiatric		
Blood in urine	Yes	No	Blood in urine	Yes	No	Insomnia	Yes	No
Kidney stones	Yes	No	Kidney stones	Yes	No	Confusion/memory loss	Yes	No
Sexual problems	Yes	No	Sexual problems	Yes	No	Anxiety	Yes	No
Testicle pain	Yes	No	Menstrual problems	Yes	No	Substance abuse	Yes	No

CERTIFICATION BY PATIENT OR RESPONSIBLE PARTY

I have reviewed the information which I have submitted and is contained in this Patient Assessment. I certify that all information given is accurate and complete to the best of my knowledge.

Patient's or Responsible Party's Signature: _____ Date: _____

CERTIFICATION BY PHYSICIAN

I have reviewed the information contained in this Patient Assessment with the patient named within or Responsible Party who submitted the information in the Patient's behalf.

Physician's Signature: _____ Date: _____

Temp _____ Pulse _____ Reg Irreg. Resp. _____