Hinsdale Orthopaedics

PATIENT ASSESSMENT

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? _____

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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	☐	☐	Glaucoma	☐	☐	Osteoarthritis	☐	☐
Alzheimers	☐	☐	Gout	☐	☐	Osteoporosis	☐	☐
Asthma	☐	☐	Heart Attack / Disease	☐	☐	Parkinsons	☐	☐
Anexiety	☐	☐	Heart Palpitations	☐	☐	Pneumonia	☐	☐
Bladder Control Problems	☐	☐	Hepatitis A, B, or C	☐	☐	Psoriasis	☐	☐
Bladder Infections	☐	☐	High Blood Pressure	☐	☐	Pulmonary Embolism	☐	☐
Bleeding Tendency	☐	☐	HIV	☐	☐	Rheumatoid Arthritis	☐	☐
Blood Clots (DVT)	☐	☐	Kidney Disease	☐	☐	Sciatica Shingles	☐	☐
Cancer	☐	☐	Liver Disease	☐	☐	Seizures	☐	☐
Coagulation Disorder	☐	☐	Lung Disease	☐	☐	Steroid Use	☐	☐
Depression	☐	☐	Lupus Erythematosus	☐	☐	Stomach Ulcers	☐	☐
Diabetes	☐	☐	Lyme	☐	☐	Stroke/TIA	☐	☐
Diverticulitis	☐	☐	Malignant Hyperthermia	☐	☐	Thyroid Disease	☐	☐
Emphysema/COPD	☐	☐	Migraine Headache	☐	☐	Tuberculosis	☐	☐
Esophageal Reflux (GERD)	☐	☐	Multiple Sclerosis	☐	☐	Varicose Veins	☐	☐

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? _____

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PAST SURGICAL/HOSPITALIZATION HISTORY

Year	Hospital/Location	Reason

Have you ever had any problems with Anesthesia? ☐ No ☐ Yes

ALLERGIES ☐ No Allergies *List any allergies you have and what type of allergic reaction you experience*

Latex Allergy	☐ No	☐ Yes	Allergic to:	Reaction:
Metal Allergy	☐ No	☐ Yes	Allergic to:	Reaction:
Medication Allergy	☐ No	☐ Yes	Allergic to:	Reaction:
Other Allergies	☐ No	☐ Yes	Allergic to:	Reaction:

MEDICATION HISTORY *Please include prescription drugs, and drugs you buy over the counter*

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

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SOCIAL HISTORY

Drugs:

Are you taking any unperscribed 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? ☐ YES ☐ NO 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
Alzheimers	☐	☐	☐	☐	Glaucoma	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	Gout	☐	☐	☐	☐	Parkinsons	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	Heart Attack / Disease	☐	☐	☐	☐	Pulmonary Embolism	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Heart Palpitations	☐	☐	☐	☐	Pneumonia	☐	☐	☐	☐
Bladder Control Problems	☐	☐	☐	☐	Hepatitis A, B, or C	☐	☐	☐	☐	Psoriasis	☐	☐	☐	☐
Bladder Infections	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐	☐
Bleeding Tendency	☐	☐	☐	☐	HIV	☐	☐	☐	☐	Sciatica	☐	☐	☐	☐
Blood Clots (DVT)	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐	Shingles	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Liver Disease	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
Coagulation Disorder	☐	☐	☐	☐	Lung Disease	☐	☐	☐	☐	Steroid Use	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Lupus Erythematosus	☐	☐	☐	☐	Stomach Ulcers	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Lyme	☐	☐	☐	☐	Stroke/TIA	☐	☐	☐	☐
Diverticulitis	☐	☐	☐	☐	Migraine Headache	☐	☐	☐	☐	Thyroid Disease	☐	☐	☐	☐
Emphysema/COPD	☐	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	☐	Tuberculosis	☐	☐	☐	☐
Esophageal Reflux (GERD)	☐	☐	☐	☐	Osteoarthritis	☐	☐	☐	☐	Varicose Veins	☐	☐	☐	☐

If other please list whom: _____

Any other medical problems not listed? _____

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REVIEW OF SYSTEMS (ROS) | *Please indicate which, if any, of the following problems you have by circling YES or NO*

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/vomitting	Yes	No
Palpatations	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. _____