

**PLEASE PRINT USING BLACK OR BLUE PEN ONLY**  
FAVOR DE IMPRIMIR CON UNA PLUMA DE TINTA NEGRA O AZUL

Patient's Name: (Last) (First) (MI)  
Nombre del paciente: (apellido) (nombre de pila) (inicial)

Patient's Age: \_\_\_\_\_ Years Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height: (Ft) \_\_\_\_\_ (In) \_\_\_\_\_ Weight: \_\_\_\_\_  
Edad del paciente: \_\_\_\_\_ años Fecha de nacimiento: \_\_\_\_\_ Altura: (pies) \_\_\_\_\_ (pulgadas) Peso: \_\_\_\_\_

This form is being completed by:  Patient  Spouse  Parent  Guardian  Other  
Este formulario es completado por:  paciente  esposo(a)  padre/madre  guardián  otro

Who is your Medical Doctor or Primary Care Physician?  
¿Cómo se llama su médico principal?

Name: \_\_\_\_\_  
Nombre: First (nombre de pila) Last (apellido)

Address: \_\_\_\_\_  
Dirección:

City: \_\_\_\_\_ State: \_\_\_\_\_  
Ciudad: Estado:

Who referred you to Hinsdale Orthopaedics? \_\_\_\_\_  
¿Quién le recomendó a Hinsdale Orthopaedics?

Referring Physician: \_\_\_\_\_  
Médico:

Occupation: \_\_\_\_\_  
Oficio/Profesión del paciente:

How long have you been doing this work?  
¿Cuánto tiempo hace que se gana la vida así?

**HISTORY OF PRESENT ILLNESS (HPI) / REASON FOR VISIT:**  
HISTORIA DE LA ENFERMEDAD CORRIENTE / RAZON POR LA VISITA:

I have brought outside films:  X-Ray  MRI  None  
He llevado conmigo de otra parte:  radiografías  MRI  nada

Which is your dominant hand?  
¿Cuál es su mano dominante?:  Right  Left  
derecha izquierda

Reason for visit today: \_\_\_\_\_  Right Extremity  Left Extremity  
Razón por la visita hoy: (Example: wrist, ankle, low back)  extremidad derecha  izquierda  
(por ejemplo: muñeca, tobillo, parte baja de la espalda)

Approximate date of the onset of the present problem: \_\_\_\_\_  
Fecha aproximada del principio de este problema

How did the problem occur? \_\_\_\_\_  
¿Cómo se le ocurrió el problema?

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"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus Erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lyme	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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? \_\_\_\_\_

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