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

Occupation: _____ Employer: _____ Employer Telephone: _____

Employer Address:_____ City: _____ State: _____ Zip Code: _____

Employer Contact Person: _____

Referring Physician: _____ Referring Physician Telephone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Primary Care Physician: _____ Primary Physician Telephone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

HEALTH INSURANCE:

Primary Insurance: _____ Policy Number: _____ Group Number: _____

Policy Holder's Last Name: _____ Policy Holder's First Name: _____

Policy Holder's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth (mm/dd/yyyy) _____ Social Security Number: _____ Insurance Telephone: _____

Employer Name: _____ Employer Telephone: _____

Employer Contact Person: _____

Employer Address:_____ City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____ Policy Number: _____ Group Number: _____

Policy Holder's Last Name: _____ Policy Holder's First Name: _____

Policy Holder's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth (mm/dd/yyyy) _____ Social Security Number: _____ Insurance Telephone: _____

WORKERS COMPENSATION INFORMATION:

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

If injury occurred at work:

Job Title:_____

Employer Name:_____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Type of work Performed: _____ Date of Injury: _____

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

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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: (**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? _____

OBSTETRICAL HISTORY (FOR FEMALES ONLY)

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

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.				

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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:

YOUR PERSONAL MEDICAL HISTORY

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

Any other medical problems not listed? _____

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

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 or a relative ever had any problems with Anesthesia? ☐ No ☐ Yes

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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

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: _____

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

	Father	Mother	Sibling	Other		Father	Mother	Sibling	Other		Father	Mother	Sibling	Other
Alzheimer's	☐	☐	☐	☐	Glaucoma	☐	☐	☐	☐	Osteoporosis	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	Gout	☐	☐	☐	☐	Parkinson's	☐	☐	☐	☐
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 selecting 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/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: _____

PREFERRED PHARMACY

Pharmacy: _____

Address: _____ Phone: _____

Temp _____ Pulse _____ ☐ Reg ☐ Irreg. Resp. _____