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

(Continued on Page 2)

Hinsdale Orthopaedics

PATIENT ASSESSMENT

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.				

(Continued on Page 3)

Hinsdale Orthopaedics

PATIENT ASSESSMENT

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	☐	☐	Osteopcrosis	☐	☐
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

(Continued on Page 4)

Hinsdale Orthopaedics

PATIENT ASSESSMENT

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? _____

(Continued on Page 5)

Hinsdale Orthopaedics

PATIENT ASSESSMENT

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. _____