Hinsdale Orthopaedic Associates, S.C.

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:_____

Who referred you to Hinsdale Orthopaedic Associates?

☐ Friend ☐ E.R./Hosp. ☐ Yellow Pages

☐ Doctor_____ ☐ Other

Occupation: How long have you been doing this work?

HISTORY OF PRESENT ILLNESS (HPI)

Where is your pain located?_____ ☐ RIGHT ☐ LEFT

(Example: Wrist, ankle, low back)

Which is your dominant hand? ☐ RIGHT ☐ LEFT

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. List past tests or treatments:_____
   (X-ray, MRI, splint, surgery, medicine, Physical Therapy, etc.)

   _____
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? How long does it last?)
6. Context of pain/problem:_____
   (Situation associated with symptom)
7. Type of pain: ☐ Burning ☐ Aching ☐ Stabbing ☐ Sharp
   ☐ Shooting ☐ Deep ☐ Other_____
8. Does the pain radiate? ☐ No ☐ Yes To where?_____
9. What measures relieve the pain? _____
10. What makes the pain worse?_____

(Continued on Page 2)

MEDICAL HISTORY

	NO	YES		NO	YES		NO	YES
Anemia	☐	☐	Heart attack	☐	☐	Shingles	☐	☐
Alzheimers	☐	☐	Heart palpitations	☐	☐	Steroid Use	☐	☐
Asthma	☐	☐	High blood pressure	☐	☐	Stomach ulcers	☐	☐
Bladder control problems	☐	☐	Kidney disease	☐	☐	Stroke/TIA	☐	☐
Bladder infections	☐	☐	Liver disease	☐	☐	Thyroid disease	☐	☐
Bleeding tendency	☐	☐	Lupus erythematosus	☐	☐	Tuberculosis	☐	☐
Blood clots (DVT)	☐	☐	Migraine headache	☐	☐	Varicose veins	☐	☐
Cancer	☐	☐	Osteoarthritis	☐	☐			
Diabetes	☐	☐	Osteoporosis	☐	☐	Anxiety	☐	☐
Diverticulitis	☐	☐	Pneumonia	☐	☐	Depression	☐	☐
Emphysema/COPD	☐	☐	Psoriasis	☐	☐	Hepatitis A, B, or C	☐	☐
Esophageal reflux (GERD)	☐	☐	Rheumatoid arthritis	☐	☐	HIV	☐	☐
Glaucoma	☐	☐	Sciatica	☐	☐	Seizures	☐	☐
Gout	☐	☐						

Any other medical problems not listed?_____

PAST SURGICAL / HOSPITALIZATION HISTORY

Year	Hospital/Location	Reason

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.			
9.			
10.			

ALLERGIES - List any allergies you have and what type of allergic reaction you experience:

☐ NO ALLERGIES

1. Allergy:	Reaction:
2. Allergy:	Reaction:
3. Allergy:	Reaction:
4. Latex Allergy: ☐ Yes ☐ No	Reaction:

(Continued on Page 3)

SOCIAL HISTORY

Do you smoke? ☐ NO ☐ YES Packs/Day_____ Years_____

Do you drink alcohol? ☐ NO ☐ YES Drinks/Day_____ Years_____

Do you take a special diet? ☐ NO ☐ YES Describe:_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated **Do you live alone?** ☐ NO ☐ YES

Home Environment: ☐ Apartment ☐ Private house ☐ Elevator ☐ Outside Steps ☐ Inside Stairs

Were you independent in your activities of daily living prior to your injury? ☐ NO ☐ YES If no, please describe:

_____

FAMILY HISTORY: (Please list any medical problems in your relatives.)

Father:_____ Mother:_____ Siblings:_____

Others:_____ _____

OBSTETRICAL HISTORY (FOR FEMALES ONLY):

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

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			
			Respiratory			**Gastrointestinal**		
Cardiovascular			Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Chest pain	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Palpitations	Yes	No	Coughing up blood	Yes	No	Rectal bleeding	Yes	No
Heart trouble	Yes	No				Bowel problems	Yes	No
Swelling hands/feet	Yes	No	**Neurological**					
			Frequent headaches	Yes	No	**Integumentary (Skin / Breast)**		
Musculoskeletal			Paralysis or tremors	Yes	No	Change in hair or nails	Yes	No
Muscle pain or cramps	Yes	No	Numbness/tingling	Yes	No	Rashes or itching	Yes	No
Stiffness/swelling joints	Yes	No				Breast lump	Yes	No
Joint pain	Yes	No	**Hematologic / Lymphatic**			Breast pain or discharge	Yes	No
Trouble walking	Yes	No	Bruise easily	Yes	No			
			Slow to heal	Yes	No	**Allergic / Immunologic**		
Endocrine			Enlarged glands	Yes	No	Food allergies	Yes	No
Excessive thirst/urination	Yes	No				Aspirin allergies	Yes	No
Hormone problem	Yes	No	**Genitourinary - Female Only**			Antibiotic allergies	Yes	No
			Blood in urine	Yes	No			
Genitourinary - Male Only			Kidney stones	Yes	No	**Psychiatric**		
Blood in urine	Yes	No	Sexual problems	Yes	No	Insomnia	Yes	No
Kidney stones	Yes	No	Menstrual problems	Yes	No	Confusion/memory loss	Yes	No
Sexual problems	Yes	No				Anxiety	Yes	No
Testicle pain	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:_____

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:_____ Physician's Signature:_____ Date:_____

Physician's Signature:_____ Date:_____ Physician's Signature:_____ Date:_____

Temp_____ Pulse_____ ☐ Reg ☐ Irreg. Resp._____