STEVEN CHUDIK MD

SHOULDER, KNEE & SPORTS MEDICINE

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4700 Gilbert Ave., Suite 51
Western Springs, IL 60558
708-387-1737

Date of Service: **Name:**	**PATIENT ASSESSMENT FORM**

Height: (Ft) _____ (In) _____ Weight: (lb) _____

This form is being completed by: [ ] Patient [ ] Spouse [ ] Parent [ ] Guardian [ ] Other

Occupation: _____ Employer: _____

Telephone: _____

Employer Address: _____ City: _____ State: ____ Zipe 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: _____

Insurance Telephone: _____

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/yyy): _____ Social Security Number: _____

Employer Name: _____ Employer Telephone: _____

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

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

Insurance Telephone: _____

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/yyy): _____ Social Security Number: _____

WORKERS COMPENSATION INFORMATION:

Did your injury occur at: [ ] Work [ ] Motor Vehicle Accident [ ] Home [ ] Sport Related [ ] Other

If injury occurred at work:

Job Title: _____

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Employer Name: _____ Employer Telephone: _____

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

Type of work performed: _____ Date of Injury: _____

Have you ever filed an injury report with your employer?: [ ] No [ ] Yes

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 today's visit: _____ [ ] 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? _____
(Example: Emergency room, family physician, etc.)

2. Have you had any past tests 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 symptoms/pain? Weeks, months, years?)

6. Types of Pain: [ ] Burning [ ] Aching [ ] Stabbing [ ] Sharp [ ] Shooting [ ] Deep [ ] Other

7. Does the pain radiate?: [ ] No [ ] Yes If yes, to where? _____

8. What measures relieve the pain? _____

9. What measures worsen the pain? _____

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.			

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

[ ] No Allergies

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

YOUR PERSONAL MEDICAL HISTORY:

	NO	YES		NO	YES		NO	YES
Alzheimer's			Heart Palpitations			Osteoarthritis		
Anemia			Heart Disease			Osteomyolitis		
Anxiety			Hepatitis A			Osteopenia		
Asthma			Hepatitis B			Osteoporosis		
Bladder Control Problems			Hepatitis C			Parkinson's Disease		
Bladder Infections			High Blood Pressure			Pneumonia		
Bleeding Tendency			High Cholesterol			Psoriasis		
Blood Clot (DVT)			HIV			Pulmonary Embolism		
Cancer			Hyperthyroidism			Rheumatoid Arthritis		
Coagulation Disorder			Hypothyroidism			Sciatica		
COPD			History of fractures			Shingles		
Depression			Kidney Disease			Seizures		
Diabetes Type I			Kidney Stones			Sleep Apnea		
Diabetes Type II			Liver Disease			Sleep Disorder		
Diverticulitis			Lung Disease			Stomach Ulcers		
Emphysema			Lupus Erythematosus			Steroid Use		
Esophageal Reflux (GERD)			Lyme			Stroke/TIA		
Gout			Malignant Hyperthermia			Thyroid Disease		
Glaucoma			Migraines			Tuberculosis		
Heart Attack			Multiple Sclerosis			Varicose Veins		

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/HOSPITILIZATION HISTORY:

Year	Hospital/Location	Reason

Have you ever had any problems with anesthesia in the past? [ ] No [ ] Yes

SOCIAL HISTORY:

Marital status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Separated [ ] Significant Other

Smoking:

[ ] Has never smoked [ ] Former smoker [ ] Exposure to passive smoke

[ ] Current occasional smoker [ ] Has been advised to quit [ ] No exposure to passive smoke

[ ] Current everyday smoker No. of packs per day: _____

Alcohol:

[ ] Does not drink alcohol [ ] daily 1-2 drinks [ ] daily heavy use

[ ] Occasional drinker [ ] daily 3-5 drinks [ ] occasional heavy use

Drugs:

Are you taking any unprescribed drugs, including recreational drugs? [ ] No [ ] Yes

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If yes, please specify: _____

Exercise:

[ ] Exercise regularly [ ] Does not exercise regularly

Residence:

Are you currently residing at a Nursing/Rehab facility? [ ] No [ ] Yes

If yes, name and address of facility: _____

YOUR FAMILY MEDICAL HISTORY (PARENT AND SIBLINGS):

(F=Father; M=Mother; S=Sibling; C=Child/Children)

	F	M	S	C		F	M	S	C		F	M	S	C
Alzheimer's					Glaucoma					Osteoarthritis				
Anemia					Gout					Osteoporosis				
Anxiety					Heart Attack					Parkinson's				
Asthma					Heart Disease					Psoriasis				
Bladder Control Problems					Hepatitis A					Pulmonary Embolism				
Bladder Infections					Hepatitis B					Rheumatoid Arthritis				
Bleeding Tendency					Hepatitis C					Sciatica				
Blood Clots (DVT)					High Blood Pressure					Shingles				
Cancer					HIV					Seizures				
Coagulation Disorder					Kidney Disease					Steroid Use				
Depression					Liver Disease					Stomach Ulcers				
Diabetes Type I					Lung Disease					Stroke/TIA				
Diabetes Type II					Lupus Erythematosus					Thyroid Disease				
Diverticulitis					Lyme					Tuberculosis				
Emphysema/ COPD					Migraine Headaches					Varicose Veins				
Esophageal Reflux (GERD)					Multiple Sclerosis									

List any other medical problems and indicate which family member:

_____

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/vomiting	Yes	No
Palpitations	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart trouble	Yes	No	Coughing up blood	Yes	No	Bowel problems	Yes	No
Swelling hands/feet	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**		

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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 on the Patient's behalf.

Physician's Signature: _____ Date: _____

PREFERRED PHARMACY:

Pharmacy: _____

Address: _____ City: _____ State: _____

Phone number: _____

Temp: _____ Pulse: _____ [ ] Reg. [ ] Irreg. Resp._____

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