RUSH
Castle Orthopaedics
2111 Ogden Avenue, Aurora, IL 60504 Phone: 630-978-3800 Fax: 630-862-3086

ESTABLISHED PATIENT HEALTH HISTORY

Name: _____ Age: _____ Date of Visit: _____

Email: _____ DOB: _____ MR#: _____

Primary Care Provider: _____ Height: ____ ft ____in Weight: _____ lbs

Referred by: ☐ Physician _____ ☐ Therapist ☐ Athletic Trainer ☐ Chiropractor ☐ None

How did you hear about us: ☐ Internet ☐ Advertisement ☐ Family Member
☐ Friend ☐ Primary Provider ☐ Other _____

Pharmacy Name and Location : _____

_____

CHIEF COMPLAINT

Why are you here today? _____

_____

Which side is affected: ☐ Right ☐ Left ☐ Both

If it involves your hand which fingers: ☐ Thumb ☐ Index ☐ Middle ☐ Ring ☐ Small

Dominant Hand: ☐ Right ☐ Left ☐ Both

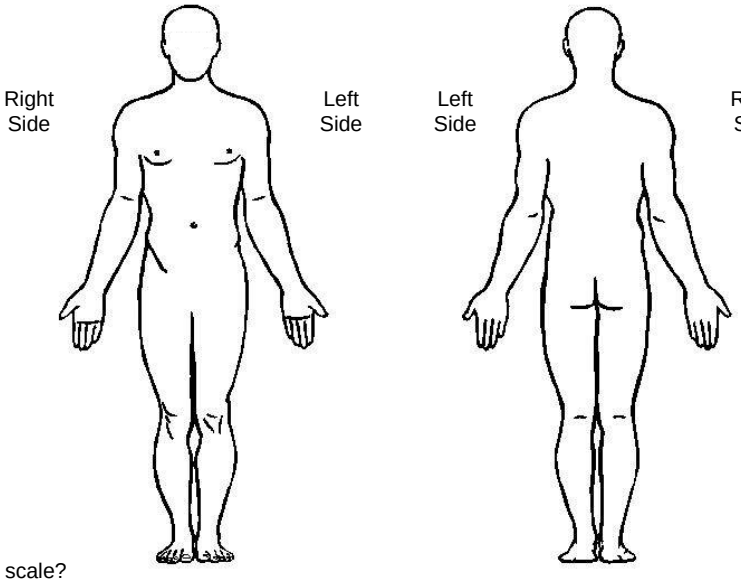
How long have you been experiencing these symptoms? _____

Did your problem result from a specific injury or accident? ☐ Yes ☐ No ☐ Workman's Compensation ☐ Auto Date of Injury_____
Describe the injury or accident: _____

_____

Mark the area or region on the diagram where you have any of the following sensations:

Ache	Numbness	Pins & Needles	Stabbing	Burning	Shooting
^ ^ ^	O O O	X X X X	/ / /	# # #	? ? ?



How bad is the pain on a 0 – 10 scale?

O	O	O	O	O	O	O	O	O	O	O
0	1	2	3	4	5	6	7	8	9	10
MILD									WORST	

Patient Name: _____

HISTORY OF PRESENT ILLNESS (Check all that apply)

Symptoms: ☐ Pain ☐ Redness ☐ Swelling ☐ Bruising ☐ Stiffness ☐ Weakness ☐ Tingling
☐ Numbness ☐ Deformity ☐ Other: _____

Location: Does the problem go to other areas? ☐ Yes ☐ No If yes, where? _____

Quality: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Stabbing ☐ Burning ☐ Shooting
Severity: ☐ Mild ☐ Moderate ☐ Severe

Onset: ☐ Gradual ☐ Recurrent ☐ Sudden
Timing: ☐ Occasional ☐ Intermittent ☐ Constant ☐ With Activity ☐ At Rest ☐ Morning ☐ At Night

Context: What are you doing when the symptoms occur?_____
Can you reproduce the symptoms? ☐ Yes ☐ No

Modifying Factors: What has made it better? _____
☐ Rest ☐ Ice ☐ Heat ☐ Over the Counter Medications ☐ Prescription Medication
What has made it worse? _____
☐ Pain increases with cough or sneezing

Prior Treatment for this? ☐ Yes ☐ No

By Whom: ☐ Primary Provider ☐ Emergency Room ☐ Another Orthopedist ☐ Chiropractor
☐ Pain Provider ☐ Rheumatologist
Form of Treatment: ☐ Medication ☐ Therapy ☐ Splinting/Casting ☐ Injection ☐ Surgery
Other Tests: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Ultrasound ☐ EMG / Nerve Testing
☐ Myelogram

REVIEW OF SYSTEMS (Check those that apply to you)

General
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight gain/loss

Eyes
- ☐ Corrective eyewear
- ☐ Eye pain
- ☐ Visual disturbance
- ☐ Blurring/double vision

Ear/Nose/Throat/Mouth
- ☐ Earache
- ☐ Frequent nose bleed
- ☐ Hearing loss
- ☐ Sinus pain
- ☐ Sore throat
- ☐ Teeth/gum problems

Respiratory
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Fainting spells
- ☐ Palpitations
- ☐ Racing heart rate
- ☐ Swollen ankles
- ☐ Leg cramps

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bladder Control Change
- ☐ Bloody Stools
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting ☐ Bloody

Genitourinary
- ☐ Bladder Control Change
- ☐ Bloody urine
- ☐ Incontinence
- ☐ Painful urination

Allergy/Immunologic
- ☐ Frequent infections
- ☐ Runny nose/sneezing
- ☐ Skin sensitivities

Neurological
- ☐ Balance problems
- ☐ Dizziness/lightheadedness
- ☐ Excessive headaches
- ☐ Memory loss or confusion
- ☐ Numbness/weakness
- ☐ Tremors/seizures

Metabolic / Endocrine
- ☐ Excessive thirst/urination
- ☐ Glandular
- ☐ Hormone problems
- ☐ Heat/cold intolerance

Dermatological
- ☐ Open wounds/sores
- ☐ Rash

Hematological
- ☐ Bruise easily
- ☐ Easy/persistent bleeding

Psychiatric
- ☐ Agitation
- ☐ Depression
- ☐ Insomnia
- ☐ Suicidal

Musculoskeletal
- ☐ Joint pain
- ☐ Stiffness
- ☐ Swelling
- ☐ Redness over joints
- ☐ Pain in neck/back
- ☐ Muscle tenderness

Female Only
- ☐ Pregnant
- ☐ Possibly Pregnant
- ☐ Menopause
- ☐ Perimenopausal

Current Medications: ☐ None

Name: _____ Dose: _____ Frequency: _____ Last Taken: _____
Name: _____ Dose: _____ Frequency: _____ Last Taken: _____
Name: _____ Dose: _____ Frequency: _____ Last Taken: _____
Name: _____ Dose: _____ Frequency: _____ Last Taken: _____

I certify that to the best of my knowledge the above information is correct.

Signature of Patient or Parent/Legal Guardian: _____ Date: _____ Time: _____

FOR OFFICE USE ONLY:

BP:
HR:
WT: HT:
Reviewed by: _____ Date: _____ Time: _____