RUSH

Castle Orthopaedics

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NEW 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? ______________________________

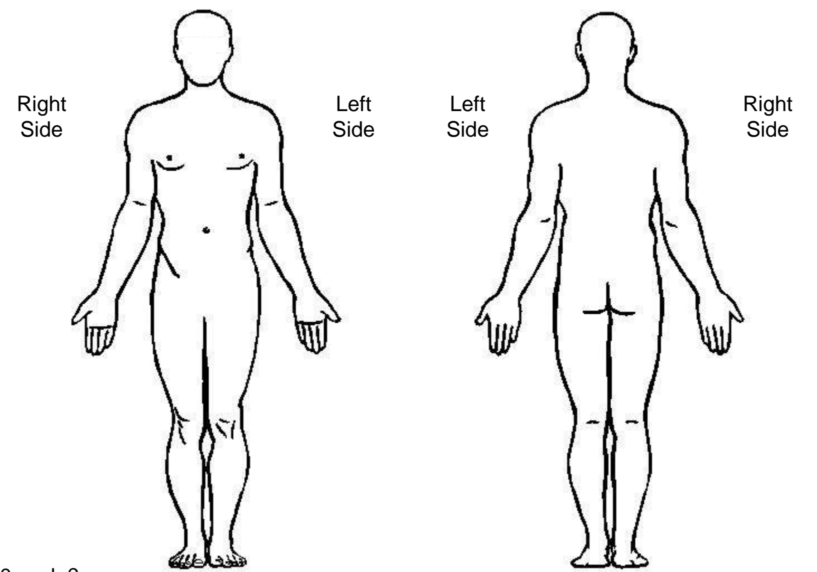
Did your problem result from a specific injury or accident? ☐ Yes ☐ No ☐ Workman's Compensation ☐ Auto Date of Injury________

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
Λ Λ Λ	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
- ☐ Bowel Control Change
- ☐ Abdominal pain
- ☐ 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

PAST MEDICAL HISTORY (Check all conditions that you have currently or have had in the past)

- ☐ AIDS/HIV Positive
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Bronchitis
- ☐ Cancer (Type: ___________)
- ☐ Chemical dependency
- ☐ Circulation problems
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes/STD
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lupus
- ☐ Lymphoma/Leukemia
- ☐ Migraine headaches
- ☐ Mitral valve prolapsed
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson disease
- ☐ Peripheral vascular disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psoriasis
- ☐ Psychiatric condition
- ☐ Renal failure
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Sleep apnea
- ☐ On C-PAP
- ☐ Stroke
- ☐ Thyroid dysfunction
- ☐ Tuberculosis
- ☐ Ulcer/Acid Reflux/GERD
- ☐ _____________
- ☐ _____________

Patient Name: ____

Current Medications: ☐ None

Name: ______________________ Dose: __________ Frequency: __________ Last Taken: __________

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Family History

Indicate blood relatives who have been diagnosed with any of the following (Check all that apply) ☐ Unknown/Adopted

	Father	Mother	Brother	Sister
Anesthetic Complications	☐	☐	☐	☐
Cancer: Type:________________	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Arthritis: ☐ Rheumatoid ☐ Osteo	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Bleeding/clotting problem	☐	☐	☐	☐

Allergies ☐ None

☐ Penicillin ☐ Keflex ☐ Sulfa ☐ Contrast / Dye

☐ Aspirin ☐ NSAIDS ☐ Latex ☐ Metal/jewelry

☐ Shellfish ☐ Other: ______________________

Surgeries and Hospitalizations

Reason: ____ Year __________

Reason: ____ Year __________

Reason: ____ Year __________

Reason: ____ Year __________

Social History

Do you currently use any of the following products?
☐ None ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ E-cigs ☐ Smokeless tobacco

How many cigarettes do you smoke per day?
☐ None ☐ Less than ½ pack ☐ ½ pack ☐ 1 pack ☐ 1 ½ packs ☐ 2 packs or more

Alcoholic beverage (a drink is 1 shot, 1 bottle of beer, or 1 glass of wine)
☐ None/Occasional ☐ 1-3 drinks per week ☐ 4-14 drinks per week ☐ greater than 2 drinks per day

Recreational Drug Usage / Type: ____
☐ Never Drug Use ☐ Former Drug Use ☐ Current Some Day Drug Use ☐ Current Every Day Drug Use

Caffeine Use (coffee, tea, chocolate, soda, energy drink)
☐ None/Occasional ☐ 1 per day ☐ 2-3 per day ☐ 4+ per day

Exercise Level (moderate activity for at least 20 minutes)
☐ None/Occasional ☐ 1-2x weekly ☐ 3+ weekly

Marital Status: ☐ Yes ☐ No ☐ Separated/Divorced ☐ Widow(er)

Do you have children? ☐ Yes ☐ No ☐ How many? ______________________

Living Arrangements:
Where do you live: ☐ House ☐ Apartment ☐ Nursing Home ☐ Assisted living ☐ Other: ______________

Who do you live with: ☐ Alone ☐ Family/Friend ☐ Other: ______________________

Occupation ☐ N/A ☐ Student ☐ Retired

Current: ______________________________________

Describe: ______________________________________

____

Sports/Activities (routinely)

____

____

____

CST-0034.9/2017

Patient Name: ____

Osteoporosis Evaluation: Check all that apply: (if you check 3 or more, ask about a DEXA scan)

Have you had a DEXA scan? ☐ Yes ☐ No if yes, when? ____

- ☐ Female
- ☐ Three or more alcoholic beverages per day
- ☐ Low intake of calcium
- ☐ Height loss in past year
- ☐ Underweight
- ☐ Blood relative with a hip fracture by 50
- ☐ Hip, wrist, spine fracture
- ☐ Smoker
- ☐ Menopause before 45
- ☐ Less than 3 exercise sessions (20 minutes) per week
- ☐ Steroid use greater than 3 months
- ☐ Four or more caffeinated drinks per day

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: ____________