Midwest Orthopaedics at RUSH

Brett R. Levine, MD, MS
Orthopaedics and Joint Replacement Surgery

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Patient History - Initial Visit

Name: _____ Date of Birth: _____ Today's Date: _____

Are you interested in physician communications via email? ☐ Yes ☐ No Email: _____

Who sent you to see us?
Name: _____
Address: _____
City, State: _____ Zip: _____
Phone Number: _____

Primary Care Physician:
Name: _____
Address: _____
City, State: _____ Zip: _____
Phone Number: _____

Why are you seeing the doctor today? _____

_____

_____

Where is your pain located? ☐ Right Hip ☐ Right Knee ☐ R Other ☐ Left Hip ☐ Left Knee ☐ L Other

How long have you had this problem? _____

Is this the result of an injury? ☐ Yes ☐ No If yes, explain: _____

Is there any litigation pending? ☐ Yes ☐ No Is your problem covered under Worker's Comp.? ☐ Yes ☐ No

If you are having **HIP PAIN**, where is it located?

☐ Groin ☐ Thigh ☐ Down below knee
☐ Side of Hip ☐ Down to knee ☐ Buttocks

If you are having **KNEE PAIN**, where is it located?

☐ Inside of knee ☐ Front of knee ☐ Unable to localize
☐ Outside of knee ☐ Back of knee

Is your pain: ☐ Getting worse ☐ Getting Better ☐ Staying the same

Is your pain: ☐ Intermittent ☐ Constant

How would you describe your pain?

☐ Sharp ☐ Throbbing ☐ Burning
☐ Dull ☐ Tight ☐ Tingling

Reviewed by: _____ *Date:* _____

Do you have pain when you:

☐ Walk ☐ Sit
☐ Stand ☐ At night

Is your pain worse when you:

☐ Walk ☐ Sit
☐ Stand ☐ At night

Rate your pain on a scale from 1-10 (1 = minimal pain, 10 = severe pain): _____

Do you have experience any of the following?

☐ Stiffness ☐ Numbness
☐ Swelling ☐ Weakness

Do you have a limp?

☐ None ☐ Moderate
☐ Slight ☐ Severe

What is the maximum distance you can walk **BEFORE** you start having pain?

☐ Unlimited ☐ 2-3 blocks ☐ 4-6 blocks
☐ Indoors only ☐ Bed to chair only ☐ Unable to walk

Do you need assistance with walking?

☐ None ☐ Walker ☐ Cane all of the time
☐ Wheelchair ☐ Cane, long walks only

Do you have difficulty going up or down stairs?

☐ None ☐ Take one step at a time
☐ Use banister always ☐ Use crutches or cannot do stairs

Do you have difficulty putting on your shoes and socks?

☐ None ☐ Unable ☐ With difficulty

Can you sit in a chair comfortably for:

☐ Any chair for more than one hour ☐ Unable to sit for 1/2 hour
☐ High chair for 1/2 hour

Can you get up from a chair:

☐ Normally ☐ Difficulty even when using my arms
☐ Use my arms ☐ Need, help, unable to do alone

Have you tried any of the following medications?

☐ Tylenol ☐ Aspirin ☐ Vioxx ☐ Celebrex ☐ Daypro
☐ Motrin ☐ Aleve ☐ Voltaren ☐ Other

Have you tried injections? ☐ Yes ☐ No

What kind of injections? ☐ Steroids ☐ Synvisc ☐ Don't Know

How many injections? _____ Approximate date of last injection: _____

Have you tried physical therapy/exercises? ☐ Yes ☐ No

Reviewed by: _____ *Date:* _____

PAST MEDICAL HISTORY

Please list all of your medical problems (i.e. hypertension, prior blood clots, diabetes, etc.…)

_____

_____

_____

_____

_____

Do you have allergies to any medications? ☐ Yes ☐ No

If yes, please describe: _____

What medications do you presently take?

Medication	Dose	Times taken per day

PAST SURGICAL HISTORY

Have you ever had a previous surgery? ☐ Yes ☐ No

If yes, please complete:

Surgery/Year	Surgeon	Hospital	Complications

Reviewed by: _____ *Date:* _____

SOCIAL HISTORY

What kind of work do you do?

☐ Homemaker ☐ Manual Labor ☐ Retired ☐ Desk Job

☐ On Disability ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Who lives at home with you? _____

Do you live in: ☐ House ☐ Apartment ☐ Other:_____

Approximately how many stairs do you walk to get into your home? _____

Approximately how many stairs do you have inside your home? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, # drinks per week: _____

Do you use illicit drugs? ☐ Yes ☐ No Describe: _____

Do you smoke? ☐ Yes ☐ No If yes, # packs per day: _____ For how many years? _____

Do you exercise regularly? ☐ Yes ☐ No How many times per week? _____

Do you follow a special diet? ☐ Yes ☐ No What kind? _____

FAMILY HISTORY

Member	Alive/Deceased	Age	Health Conditions
Father			
Mother			
Sibling			
Sibling			
Sibling			
Sibling			

OTHER INFORMATION

Have you ever had a blood transfusion? ☐ Yes ☐ No

Have you ever had a problem with anesthesia? ☐ Yes ☐ No

Have you ever had a blood clot in your leg or lung? ☐ Yes ☐ No

Height: _____ Weight: _____

Reviewed by: _____ *Date:* _____

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Do you currently or have you ever had problems with any of the following that you did NOT list elsewhere?

Constitutional

Recent weight loss	□ Yes	□ No
Recent fevers	□ Yes	□ No

Eyes

Wear glasses	□ Yes	□ No
Cataracts	□ Yes	□ No
Glaucoma	□ Yes	□ No

Ears, nose, throat, mouth

Sinus problems	□ Yes	□ No
Active dental problems	□ Yes	□ No

Cardiovascular

Heart attack	□ Yes	□ No
Heart Murmur	□ Yes	□ No
Irregular heart beat	□ Yes	□ No
High blood pressure	□ Yes	□ No
High cholesterol	□ Yes	□ No

Respiratory

Asthma	□ Yes	□ No
Bronchitis	□ Yes	□ No
Emphysema	□ Yes	□ No
Pneumonia	□ Yes	□ No
Tuberculosis	□ Yes	□ No

Gastrointestinal

Colitis	□ Yes	□ No
Diverticulitis	□ Yes	□ No
Ulcer	□ Yes	□ No
Hernia	□ Yes	□ No
Hepatitis/Liver problem	□ Yes	□ No

Genitourinary

Prostate problem	□ Yes	□ No
Kidney problem	□ Yes	□ No
Bladder infections	□ Yes	□ No

Musculoskeletal

Rheumatoid Arthritis	□ Yes	□ No
Ankylosing Spondylitis	□ Yes	□ No
Lupus	□ Yes	□ No
Osteoporosis	□ Yes	□ No
Paget's Disease	□ Yes	□ No

Skin

Psoriasis	□ Yes	□ No
Eczema	□ Yes	□ No
Dermatitis	□ Yes	□ No

Neurological

Seizures/Epilepsy	□ Yes	□ No
Polio	□ Yes	□ No
Parkinson's Disease	□ Yes	□ No
Alzheimer's Disease	□ Yes	□ No
Balance problems	□ Yes	□ No

Psychiatric

Depression	□ Yes	□ No
Schizophrenia	□ Yes	□ No

Endocrine

Diabetes	□ Yes	□ No
Thyroid	□ Yes	□ No

Hematologic/Blood

Blood clots	□ Yes	□ No
Anemia	□ Yes	□ No

Cancer

What kind? _____

Other: _____

_____

Reviewed by: _____ *Date:* _____