Midwest Orthopaedics at RUSH

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Orthopaedics and Joint Replacement Surgery

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Patient History—ER Visit

Name: ______________________________ Date of Birth: ____________ Today's Date: ____________

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

Primary Care Physician: Name: ____

Address: ____

City, State: ________________________ Zip: ___________________

Phone Number: ____

Why are you seeing the doctor today? ____

____

____

Where is your pain located? ____

How long have you had this problem? ____

Have you injured this extremity before? __________________

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

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

Reviewed by: ________________________ *Date:* _______________

PAST SURGICAL HISTORY

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

If yes, please complete:

Surgery/Year	Surgeon	Hospital	Complications

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? _______

Height: _______ Weight: _______

Reviewed by: ________________________ *Date:* _______________

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:* ______________