LAKE COOK ORTHOPEDICS

LAKE COOK ORTHOPEDICS PATIENT HISTORY FORM

Today's Date: _____ Patient name: _____

Referring physician _____City _____ Phone # _____

Primary care physician _____ City_____ Phone # _____

*If your visit is related to an injury, circle the appropriate response below. If it is not related to an injury, please fill out the reason for your visit here: _____.

The injury is due to: car accident work injury sports injury fall other _____

The injury occurred at: home work school other _____

Are you off work due to the injury: Yes No If yes, last day worked _____

If no, any restrictions _____

Is legal action/litigation pending due to this injury? Yes No

Date of injury/onset _____/_____/_____ Symptoms_____

Location of symptoms_____ Right☐ Left☐ Both☐ N/A☐

Circle each & every characteristic that BEST describes your problem:

QUALITY: Sharp / Dull / Throbbing / Aching / Burning / Cramping

SEVERITY: Mild / Moderate / Severe / Rate on a scale 1-10 with 10 being the worst _____

DURATION: Infrequent / Intermittent / Constant / Hourly / Daily / Weekly

TIMING: During activity/ After activity / Walking / Running / Stairs / Squatting / Pivoting / Overhead use / Throwing / Lifting / Other _____

CONTEXT: Improving / Worsening / Recurrent / More frequent / Less Frequent / Unchanged

SYMPTOM RELIEF: Rest / Heat / Cold / Elevation / Physical therapy / Brace / Injection / Medication / Other _____

SYMPTOM AGGRAVATION: Activity / Position change / Repetitive motion / Fatigue / Other_____

ASSOCIATED SYMPTOMS:_____

MEDICATIONS (PRESCRIPTION / NONPRESCRIPTION / HERBAL SUPPLEMENTS / VITAMINS / OTHER):

MEDICATION	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION

IF THERE ARE ADDITIONAL MEDICATIONS, PLEASE PROVIDE ON BACK OF FORM

Do you have allergies? Y N If yes, please list allergies & describe reaction _____

Pharmacy of choice:

Name Street Address, City, State Phone # Mail order?

1. _____ _____ _____ Y / N

2. _____ _____ _____ Y / N

PATIENT HISTORY FORM CONTINUED

If you are permanently or temporarily residing in a skilled medical nursing facility/long term care facility/nursing home or rehabilitation center please complete below:

Facility name:_____City _____Dates _____

PAST MEDICAL AND FAMILY HISTORY: PLEASE CHECK THOSE THAT APPLY

	Self	Father	Mother	Sibling	Child	Grandparent		List any other medical conditions
1. Arthritis								
2. Asthma								
3. Cancer								
4. Diabetes								
5. Emphysema								
6. Glaucoma								
7. Heart disease								
8. Hepatitis								
9. High blood pressure								
10. Kidney disease								
11. Neurological disease								
12. Seizures								
13. Stroke								
14. Thyroid problem								
15. Stomach ulcers								

PAST SURGICAL HISTORY:

Procedure _____ Surgeon _____ Date _____

Procedure _____ Surgeon _____ Date _____

Procedure _____ Surgeon _____ Date _____

Procedure _____ Surgeon _____ Date _____

Procedure _____ Surgeon _____ Date _____

SOCIAL HISTORY: Circle one for each that apply below

Tobacco use: every day smoker / occasional smoker / heavy smoker / never smoked/ former smoker

Year started smoking _____ Year Quit _____ Are you pregnant? Y N

Alcohol use: How many drinks per week? _____ History of alcoholism: Y N History of drug use: Y N

Do you live alone? Y N If no, who do you live with? _____**Height _____Weight _____**

CONSENT TO TREAT/EVALUATE: I, for myself, or the patient named on this form, hereby consent to such medical evaluation (e.g. IME) and/or treatment and diagnostic procedures (e.g. x-rays, MRI, therapy) as necessary and appropriate for my condition or illness based on the judgment of my physician(s), to be performed by the physician(s), physician(s) assistant(s), nurse(s) or other health care provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my health care provider, ask questions regarding such treatment options and understand the options discussed.

Patient's signature: _____ Date: _____
(Parent/legal guardian if patient is a minor)