

Lake Cook Orthopedic Associates

PATIENT HISTORY FORM

Note to patients: We cannot adequately treat your problem without the information detailed below. The federal and state governments require that we be as complete as possible in our documentation of your medical record. Thank you for taking the time to fill out these forms.

Today's Date: _____ Family doctor: _____

Last Name: _____ First Name: _____ Middle: _____

Chief Complaint: What is the reason for your visit today?

*REASON: _____

History of Present Illness:

1. Location: Name area(s) involved: _____

2. Severity: (on a 1-10 scale with 10 being the worst): _____

3. Quality: Describe the problem: dull, sharp, etc. _____

4. Duration: How long has it been a problem: _____

5. Timing: When does your problem occur? _____

6. Context: Is the problem getting worse, better, unchanged? _____

7. Modifying factors: What makes it worse, or better? _____

8. Is this due to an injury? Yes No
If yes, complete the following:
Date of injury _____
Workmen's compensation? Yes No Are you off work? Yes No Date last worked _____
Auto Accident? Yes No

Medications

If yes, please list your medications and dosages, including vitamins and herbs. _____

Allergies

Do you have any allergies? Yes No
If yes, please list allergies and describe the reaction: _____

Past Medical History

Please circle yes or no if you have any of the following diseases:

- | | | | |
|-----------------------|-----------|-------------------------------|-----------|
| 1. Arthritis..... | Yes....No | 9. High Blood Pressure..... | Yes....No |
| 2. Asthma..... | Yes....No | 10. Kidney Disease | Yes....No |
| 3. Cancer..... | Yes....No | 11. Neurological Disease..... | Yes....No |
| 4. Diabetes..... | Yes....No | 12. Seizures..... | Yes....No |
| 5. Emphysema..... | Yes....No | 13. Stroke..... | Yes....No |
| 6. Glaucoma..... | Yes....No | 14. Thyroid Problem..... | Yes....No |
| 7. Heart Disease..... | Yes....No | 15. Stomach Ulcers..... | Yes....No |
| 8. Hepatitis..... | Yes....No | 16. Other, please list: _____ | |

Family Medical History

Please List any serious medical problems in your immediate family: _____

Past Surgical History

Please list any surgeries you have had done and the approximate year: _____

Social History

Do you work? Yes No
If yes describe your occupation: _____
Do you smoke? Yes No
If yes please list how much you smoke per day and for how long: _____
If no please state when you quit and how many pack years you have: (multiply the number of packs per day by the number of years you smoked)

_____ Do you drink alcohol? Yes No
If yes please list how much: _____

HEIGHT: _____ WEIGHT: _____

FOR WOMEN: IS THERE ANY CHANCE YOU ARE PREGNANT? Yes No

To the best of my knowledge all of the preceding answers are true and correct. If I have any change in my medical, I will inform Lake Cook Orthopedics at my next appointment, or by phone if no visits are scheduled. I understand that failure to disclose my medical condition may jeopardize my health.

I give my consent to any examination and any necessary X-rays.

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