RUSH
Castle Orthopaedics

Patient Health Questionnaire
IDN13150147

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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: _____
_____

For Clinical Staff: HT _____ WT _____ BP _____ HR _____

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

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

Patient Name: _____ **DOB:** _____

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	☐	☐	☐	☐

REVIEW OF SYSTEMS (Check those that apply to you)

General
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain

Eyes
- ☐ Eye pain
- ☐ Visual disturbance

Ear/Nose/Throat/Mouth
- ☐ Earache
- ☐ Sore Throat
- ☐ Frequent nose bleed
- ☐ Hearing loss
- ☐ Sinus pain
- ☐ Runny Nose
- ☐ Teeth/gum problems

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Leg Swelling

Gastrointestinal
- ☐ Abdominal pain
- ☐ Bloody Stools
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Bladder Control Change
- ☐ Bloody urine
- ☐ Urgency
- ☐ Painful urination

Allergy/Immunologic
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

Neurological
- ☐ Light Headedness
- ☐ Dizziness
- ☐ Excessive headaches
- ☐ Numbness
- ☐ Weakness
- ☐ Tremors
- ☐ Seizures

Metabolic / Endocrine
- ☐ Excessive thirst
- ☐ Excessive Urination
- ☐ Heat Intolerance
- ☐ Cold intolerance

Dermatological
- ☐ Open wounds/sores
- ☐ Rash

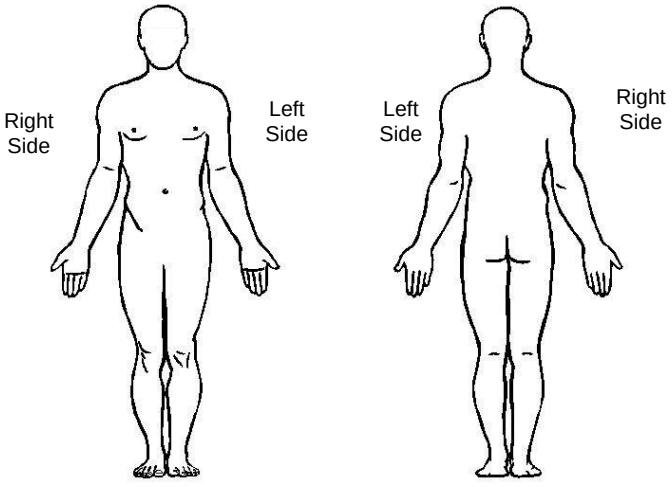
Hematological
- ☐ Bruise Easily
- ☐ Easy/Persistent Bleeding

Psychiatric
- ☐ Agitation
- ☐ Depression
- ☐ Insomnia
- ☐ Suicidal

Musculoskeletal
- ☐ Joint pain
- ☐ Pain in Back
- ☐ Joint Swelling
- ☐ Pain in neck/back
- ☐ Muscle tenderness

Mark the area or region on the diagram where you have any of the following sensations:

Ache	Numbness	Pins & Needles	Stabbing	Burning	Shooting
^ ^ ^	O O O	X X X X	/ / /	# # #	? ? ?



Patient Name: _____ **DOB:** _____

☐ CHANGES SINCE LAST VISIT

Allergies ☐ None

☐ Penicillin ☐ Keflex ☐ Sulfa ☐ Contrast / Dye

☐ Aspirin ☐ NSAIDS ☐ Latex ☐ Metal/jewelry

☐ Shellfish ☐ Other: _____

Pharmacy Name and Location: _____

_____

_____

Current Medications: ☐ None

Name: _____ Dose: _____ Frequency: _____ Last Taken: _____

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Name: _____ Dose: _____ Frequency: _____ Last Taken: _____

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

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

Surgeries and Hospitalizations

Reason: _____ Year _____

Reason: _____ Year _____

Reason: _____ Year _____

Reason: _____ Year _____

Patient Name: _____ **DOB:** _____

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)

_____

_____

_____

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: _____