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Orthopaedics and Joint Replacement Surgery

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

**PAST MEDICAL HISTORY**

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

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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

### 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: \_\_\_\_\_

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: \_\_\_\_\_  
 \_\_\_\_\_