

PATIENT INTAKE SHEET

Name _____ Sex: M/F Age _____ Date _____

Visit: ___New ___Follow-up ___ER follow-up (Date in ER _____)

Height _____ Weight _____

Reason for being seen (List detailed symptoms, location and progress, and description of pain)

Example: I am having pain in my right hip with radiation down to my knee, and weakness.

Approximate date of onset _____

Have you had surgery for this problem (What, Where, and When)?

Have you had any of the following performed for this problem?

___X-Ray ___MRI ___CT Scan ___EMG ___Other, please specify _____

Where and When? _____

Cortisone injections? Yes No # of injection _____ Dates _____

Medications for this problem:

Have you had physical therapy for this problem? ___Yes___No

Sports in which you participate _____ ___Daily ___3-5 x Weekly ___Occasionally

Past Medical History—Have you been treated for any of the following problems?

- | | | |
|-----------------------------|----------------------------|---------------------|
| ___Heart | ___Lungs | ___Liver |
| ___Kidney | ___Ulcers | ___Poor Circulation |
| ___Blood Pressure(high/low) | ___Diabetes (Insulin? Y/N) | ___Arthritis |
| ___Psoriasis | ___Cancer (Where? _____) | ___Seizures |
| ___Stroke | ___Infections | ___Anemia |
| ___Bleeding Disorder | ___Blood Clots | ___Psychiatric |
| ___Hepatitis | ___HIV/AIDS | ___Thyroid Disease |
| ___Asthma | ___Depression/Anxiety | |

Referred for Opinion & Consult by _____

How did you learn about Suburban Orthopaedics?

- | | |
|--|---------------|
| <input type="radio"/> Referred by physician | Yellow Pages |
| <input type="radio"/> Newsletter/direct mail | Radio |
| <input type="radio"/> Newspaper | Word of mouth |
| <input type="radio"/> Other _____ | Internet |

REVIEWED BY: _____

PATIENT'S SIGNATURE

PATIENT NAME: _____

Today's Date: _____

DATE OF BIRTH: _____

Please list allergies to medications or state **NONE** (Name Reaction)

Medications for medical problems (Name & Dosage) _____

List what surgery (s) you have had? (Approximate dates) _____

Complications from surgery or anesthesia? _____

FAMILY MEDICAL HISTORY:

Maternal Grandmother: ___ Alive ___ Deceased ___ Healthy ___ Fair ___ Poor

Maternal Grandfather : ___ Alive ___ Deceased ___ Healthy ___ Fair ___ Poor

Paternal Grandmother : ___ Alive ___ Deceased ___ Healthy ___ Fair ___ Poor

Paternal Grandfather : ___ Alive ___ Deceased ___ Healthy ___ Fair ___ Poor

Mother: ___ Alive ___ Deceased ___ Healthy ___ Fair ___ Poor

Father : ___ Alive ___ Deceased ___ Healthy ___ Fair ___ Poor

Sister # ___ : ___ Alive ___ Deceased ___ Healthy ___ Fair ___ Poor

Brother # ___ : ___ Alive ___ Deceased ___ Healthy ___ Fair ___ Poor

Daughter # ___ : ___ Alive ___ Deceased ___ Healthy ___ Fair ___ Poor

Son # ___ : ___ Alive ___ Deceased ___ Healthy ___ Fair ___ Poor

Family History—Problems in direct relatives:

___ Arthritis	___ Rheumatoid Arthritis	___ Heart Attack	___ Psychiatric Problems
___ Cancer	___ High Blood Pressure	___ Diabetes	___ Obesity
___ Heart Failure	___ Liver Disease	___ Stroke	___ Kidney Disease
___ Sickle Cell Disease	___ Epilepsy	___ Osteoporosis	

Social History:

Tobacco: ___ Yes ___ No Quit (when)? _____ How many years? ___
___ Cigarette ___ Pipe ___ Cigar ___ Chew

Alcohol use: ___ Heavy ___ Moderate ___ Social ___ Occasional
___ None

Substance Abuse: ___ Yes ___ No Type _____

Current Work Status: ___ Employed ___ Unemployed ___ On Disability ___ Homemaker
___ Full Time ___ Part Time

Marital Status ___ Single ___ Married ___ Divorced ___ Widowed ___ Other

Patient's Signature: _____

Reviewed By: _____

Name: _____

Date of Birth: _____

REVIEW OF SYSTEMS

DO YOU HAVE A HISTORY OF CANCER? NO YES

If yes please explain. _____

ROS HEAD/EARS/EYES

- CATARACTS
- GLAUCOMA
- GLASSES/CONTACTS
- HEARING AIDS
- HEARING LOSS
- RINGING IN EARS

ROS NOSE/SINUSES/THROAT/MOUTH

- SLEEP APNEA

ROS SKIN

- HERPES SIMPLEX
- PSORIASIS
- RASH
- SKIN COLOR CHANGE
- SKIN INFECTION

ROS BREAST

- CANCER
- BENIGN GROWTH
- CURRENTLY BREAST FEEDING

ROS CARDIOVASCULAR

- ANGINA
- ANGIOPLASTY
- ARRHYTHMIA
- CARDIAC SURGERY
- CONG. HEART FAILURE
- HEART ATTACK
- HIGH CHOLESTROL
- HYPERTENSION
- MITRAL VALVE PROLAPSE
- MURMUR
- PACEMAKER
- RHEUMATIC FEVER

ROS GI

- ASA/NSAID/D/O
- CIRRHOSIS
- CROHNS DISEASE
- DIVERTICULITIS
- HEPATITIS? TYPE _____
- HEPATITIS A
- HEPATITIS B
- HEPATITIS C
- HIATAL HERNIA
- PANCREATITIS
- REFLUX
- ULCERATIVE COLITIS
- ULCERS
- VOMITING

ROS GU

- ACUTE RENAL FAILURE
- CHRONIC RENAL FAILURE
- DIALYSIS
- LOSS OF ONE KIDNEY
- ONLY HAS ONE KIDNEY
- KIDNEY STONES
- NEPHROTIC SYNDROME
- PROSTATITIS
- TRANSPLANT

ROS OB-GYN

- PREGNANT
- _____ WEEKS PREGNANT
- NOT SURE IF PREGNANT

(CONTINUE)

PATIENT NAME: _____

Today's Date: _____

ROS RESPIRATORY

- ASTHMA
- BRONCHITIS
- CHEST PAIN
- COPD EMPHYSEMA
- COUGH BLOOD
- SARCOIDOSIS
- SIDS
- SUDDEN SOB
- TB

ROS NEUROLOGICAL

- ALZHEIMERS
- BIPOLAR DISORDER
- BRAIN ANEURYSM
- DEPRESSION
- DIABETIC NEUROPATHY
- EPILEPSY
- MULTIPLE SCLEROSIS
- OCD
- PARALYSIS
- PARKINSON
- PERIPHERAL NEUROPATHY
- POLIO
- SEIZURES
- STROKE CVA
- STROKE RESIDUAL
- TRIGEMINAL NEURALGIA

ROS ENDOCRINE

- DIABETES
- DIET DIABETES
- TYPE 2 DIABETES
- UNSULIN DIABETES
- HASHIMOTOS DISEASE
- HYPERTHYROID
- HYPOTHYROID

ROS IMMUNE SYSTEM

- AIDS
- BLOOD TRANSFUSION
- IMMUNE SUPPRESSION
- IV DRUG ABUSE

ROS MUSCULOSKELETAL

- BONE CANCER
- DJD/OA
- FIBROMYALGIA
- GOUT
- LUPUS
- OSTEOPOROSIS
- RHEUMATOID ARTHRITIS
- RSD
- SJORGENS DISEASE

ROS HEMATOLOGIC/LYMPHATIC

- ANEMIA
- APLASTIC ANEMIA
- BLEEDING DISORDER
- HEMOPHILIA
- LOW PLATELETS (Thrombocytopenia)
- POLYCYTHEMIA VERA
- SICKLE CELL DISEASE
- SICKLE CELL TRAIT
- THALASSEMIA
- VON WILLENBRAND

ROS VASCULAR

- ANEMIA
- BLOOD CLOT
- CLAUDICATION
- DVT
- HEMOPHILIA
- PHLEBITIS
- PULMONARY EMBOLISM
- RAYNAUDS
- VARICOSE VEINS

Patient's Signature: _____

Reviewed By: _____

Date: _____