Patient Intake Sheet

orthoNY Your bone and joint experts

Name:
Date of Birth:

Today's Date:

Phone:____________________**Email:**___________________________**Marital Status** _________________

Age_____ Gender________ Height _________ Weight _________ Hand Dominance RIGHT LEFT

Please list all Allergies	**Reaction:**

Are you allergic to latex / rubber products? YES NO

Current Occupation: _____________________________________Highest Level of Education ________________

Reason for visit (please list side if applicable): ____

Date of injury / when did symptoms start: _____________________

Is this a work related accident? YES NO Is this related to a motor vehicle accident? YES NO
Are you currently working ? YES NO If no, date last worked: ________________

Have you had any test(s) for this injury? **YES NO if YES, please circle all that apply**

X-rays CAT Scan MRI Nerve Studies Blood Studies

If **YES**, where were they performed? ____

Have you had any treatment for this injury? (physical therapy, cortisone injections, other) **YES NO**

If **YES**, please list type of treatment____

Referring MD: _________________________Primary Care MD: _____________________________

Current Pharmacy: ____

Have you ever had an infection that was resistant to antibiotics, such as MRSA? YES NO
Do you smoke? YES NO If yes, how much per day? __________ Former Smoker? YES NO
Do you drink alcohol? YES NO If yes, how much? ______drinks Per day Per week
Do you take addictive drugs? If yes, what? ____
Do you know that you are now, or could possibly be pregnant? YES NO Not Applicable

Pain Scale Please rate your pain on a scale on 0-10, zero being none and 10 being unbearable

0	1	2	3	4	5	6	7	8	9	10

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Past Surgical History

Date	Type of surgery and if extremity, which extremity

Current Medication, including dose and frequency

Medication	Dose	How often

Review of Systems
Do you have any of these symptoms?
Please circle Yes or No for each

Constitutional			**Heart**			**Neurological**		
Fever or Chills	Yes	No	Chest Pain	Yes	No	Balance / Coordination	Yes	No
Weight Loss / Gain	Yes	No	Irregular Heartbeat	Yes	No	Changes in Sensation	Yes	No
						Muscle Weakness	Yes	No
Endocrine Function	Yes	No	**Hematopoietic/Lymph**			Numbness in hands/feet	Yes	No
Hot Flashes	Yes	No	Easy Bruising / Bleeding	Yes	No	Tingling in hands / feet	Yes	No
Cold Sensitivity	Yes	No	Extremity Swelling	Yes	No	Visual Changes	Yes	No
Gastrointestinal			**Immunologic**			**Respiratory**		
Diarrhea	Yes	No	Frequent infections	Yes	No	Shortness of breath	Yes	No
Stomach Pain	Yes	No	Viral infections	Yes	No			
Genitourinary			**Musculoskeletal**			**Skin**		
Frequent urination	Yes	No	Joint Pain	Yes	No	Dryness of Skin	Yes	No
Wake at night to urinate	Yes	No	Joint Swelling	Yes	No	Rashes	Yes	No
Difficulty postponing urination	Yes	No	Muscle Aches	Yes	No			
Pain when urinating	Yes	No						

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Current/Past/Family History

Please review the following medical conditions and note if
A) You have this condition currently
B) Have had this condition in the past or
C) Know of a family member who has had this condition.
Please circle Yes or No for each.

	Current Condition		Past Condition		Present in Family	
Anemia	Yes	No	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	Yes	No
Bleeding Tendency	Yes	No	Yes	No	Yes	No
Blood Clots	Yes	No	Yes	No	Yes	No
Bronchitis/Asthma/Emphysema	Yes	No	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Yes	No
Depression	Yes	No	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Yes	No
Enlarged Prostate (men only)	Yes	No	Yes	No	Yes	No
Fibromyalgia	Yes	No	Yes	No	Yes	No
Gout	Yes	No	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No	Yes	No
Hepatitis	Yes	No	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No	Yes	No
Immune Deficiency Disorder/HIV	Yes	No	Yes	No	Yes	No
Kidney Disease	Yes	No	Yes	No	Yes	No
Liver Disease	Yes	No	Yes	No	Yes	No
Malignant Hyperthermia	Yes	No	Yes	No	Yes	No
Neuropathy	Yes	No	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No	Yes	No
Peripheral Vascular Disease	Yes	No	Yes	No	Yes	No
Psoriasis	Yes	No	Yes	No	Yes	No
Reflux/GERD	Yes	No	Yes	No	Yes	No
Seizures	Yes	No	Yes	No	Yes	No
Sleep Apnea	Yes	No	Yes	No	Yes	No
Stroke/TIA	Yes	No	Yes	No	Yes	No
Thyroid Disease	Yes	No	Yes	No	Yes	No
Ulcers	Yes	No	Yes	No	Yes	No
Other (please specify)						

Patient's Signature **Date** **reviewed – initial and date**

Physician's Signature **Date** **reviewed – initial and date**