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UNIVERSITY ORTHOPEDICS

THE CENTER FOR orthopaedics INC.

Intake Form

Name: _____ **Date of Birth:** _____

Today's Date: _____

Referring Physician: _____ **Primary Care:** _____

What is your chief complaint? Why are you here today?: _____

Date of Injury (if applicable): _____

What symptoms are you experiencing? _____

Please rate your pain: □ None □ Mild □ Moderate □ Severe

How frequent are your symptoms? □ Constant □ Intermittent

Is this injury related to work? □ Yes □ No

Is there a Workman's Compensation claim for this injury? □ Yes □ No **Claim #**_____

Are you currently employed? □ Yes □ No

What is your occupation? _____

Were you injured in a motor vehicle accident? □ Yes □ No **If injured, is there a question of litigation?** □ Yes □ No

Alcohol intake: □ None □ Occasional □ Moderate □ Heavy

Smoking Status:

□ Never smoker □ Former smoker □ Current every day smoker □ Current some day smoker

□ Smoker- current status unknown □ Unknown if ever smoked

Tobacco years of use: _____

Current Height: _____ **Current Weight:** _____

Allergies:

Are you allergic to Latex? YES NO

List any medication(s) allergies and your reaction(s):

_____

_____

Name:_____ **DOB:**_____

Medications: Please list all prescription, OTC Medication with dosages, and vitamins.

Medication	Dose	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: Please circle if your *PARENTS/SIBLINGS* have a history of the following:

Bleeding coagulation disorder	Family history of neurological disorder	Hereditary Disease
Complications with Anesthesia	Heart disease	Rheumatoid Arthritis

Family history of Cancer: _____

Surgical History: Please circle any surgeries below:

Appendectomy	Heart (CABG)/Stents	Pacemaker	Total Joint Replacement: _____
Ear/Nose/Throat	Hernia	Prostate (TURP)	Vascular
Eye	Hysterectomy	Spine	
Gallbladder	Lung	Stomach/Bowel	
Gastric Bypass	Orthopedic Surgery	Thyroid	

Medical History: Please circle any known problems below:

❑ A-Fib	❑ Emphysema / COPD / Cough	❑ Peripheral Vascular Disease
❑ AIDS / HIV	❑ Fibromyalgia	❑ Pneumonia
❑ Anemia	❑ Gout	❑ Prostate Enlargement
❑ Anxiety / Depression	❑ Heart Disease (MI)	❑ Pulmonary Embolism
❑ Are you currently Pregnant?	❑ Hepatitis (A, B, C)	❑ Reflux/GERD
❑ Asthma	❑ High Blood Pressure	❑ Rheumatoid Arthritis
❑ Bipolar Disorder	❑ Kidney Disease / Failure	❑ Seizures/Epilepsy
❑ Blood Clots	❑ Liver Disease	❑ Sleep Apnea
❑ Blood Transfusion	❑ Lupus	❑ Stroke
❑ C-Diff	❑ Lymphedema	❑ Substance Abuse
❑ Colitis	❑ Malignant Hypothermia	❑ Tuberculosis
❑ Complications from anesthesia	❑ Mental Illness	❑ Thyroid Problems (Hi / Low)
❑ Connective Tissue Disorder	❑ MRSA / VRE	❑ Visual Problems
❑ Diabetes	❑ Osteoporosis	❑ Other: _____
	❑ Panic Disorder	

Cancer:

Type:_____

Surgery/Radiation/Chemotherapy:_____

Name:_____ DOB:_____

Review of Systems: Do you at present have any of the following problems? Please circle for **YES**.

Constitutional:
Fevers
Chills
Weight Loss
Weight Gain

Eyes:
Blindness
Blurriness
Cataracts

ENT:
Hearing
Loss
Ringing
Nosebleeds

Cardiovascular:
Chest Pain
Tightness
Palpitations

Respiratory:
Cough
Wheezing
Shortness of Breath

Gastrointestinal:
Heartburn
Nausea
Reflux

Genitourinary:
Frequency
Urgency

Skin:
Itching
Lumps
Rashes
Blisters
Ulcers
Redness
Bruising

Musculoskeletal:
Joint Pain
Swelling
Stiffness

Neurological:
Dizziness
Numbness
Tingling
Burning
Tremors
Weakness

Psychiatric:
Anxiety
Depression
Memory Loss

Endocrine:
Excessive Thirst
Temperature Intolerance

Hematologic:
Easy Bruising
Easy Bleeding

Immunologic:
Severe Allergy
Frequent Infections

Additional Comments:

_____

_____

_____

Patient: The above information I have supplied is complete, true, and correct to the best of my knowledge.

Patient Signature: _____

Date: _____