



## Eastern Orthopaedics & Sports Medicine Medical Intake Sheet

Name: \_\_\_\_\_

Today's Date: \_\_\_/\_\_\_/\_\_\_

### HISTORY OF PRESENT ILLNESS

Date of Birth: \_\_\_/\_\_\_/\_\_\_      Age: \_\_\_\_\_      Sex: Male\_\_\_ Female\_\_\_

Height: \_\_\_' \_\_\_"      Weight: \_\_\_\_\_lbs      Hand Dominance: \_\_\_Right \_\_\_Left

Who referred you to our office? \_\_\_\_\_

Chief Complaint (What brought you here today): \_\_\_\_\_

How long have you had symptoms? \_\_\_\_\_

Date of injury or onset of symptoms: \_\_\_/\_\_\_/\_\_\_

Please briefly describe your injury or symptoms: \_\_\_\_\_

Do you have any previous injury to this area of the body? \_\_\_Yes \_\_\_No

Have you had any treatment for this condition prior to your visit today?

- |   |                                      |                                     |                                      |
|---|--------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> X-rays           | <input type="checkbox"/> MRI         | <input type="checkbox"/> CT Scan    | <input type="checkbox"/> Cast/Splint |
| <input type="checkbox"/> Crutches         | <input type="checkbox"/> Wheelchair  | <input type="checkbox"/> Walker     | <input type="checkbox"/> Cane        |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Medications | <input type="checkbox"/> Injections | <input type="checkbox"/> Surgery     |

### PAST MEDICAL HISTORY

Do you currently have or have you ever been treated for any of the following medical conditions?

Condition	Yes	No	Condition	Yes	No
Asthma			Ulcers/Acid Reflux/GERD		
Tuberculosis			Osteoporosis/Osteopenia		
COPD			Hypo/Hyperthyroid		
Heart Disease/Pacemaker			Diabetes mellitus Type I/Type II		
Heart Attack/Angina			Renal Failure/Kidney Disease		
High Cholesterol			Hepatitis/Liver Disease Cirrhosis		
High Blood Pressure			Cancer:		
Anemia			Sexually Transmitted Disease/HIV/AIDS		
Peripheral Vascular Disease			Other:		
Blood Transfusion					

### Past Surgical History

Please list any previous hospitalizations or surgeries you have had, the dates they occurred, and surgeon.

### Medications

Please list any current medications you take, the dosage, and frequency that you take them. Include prescriptions, vitamins/supplements, and herbal medications.

**ALLERGIES**

Please list any allergies that you have to food, medications, or latex. \_\_\_\_\_

**FAMILY HISTORY**

Indicate family members who have been diagnosed with any of the following:

	<b>Father</b>	<b>Mother</b>	<b>Brother</b>	<b>Sister</b>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SOCIAL HISTORY**

Which is your dominant hand? \_\_\_ Right \_\_\_ Left

Are you currently employed? Yes \_\_\_ No \_\_\_

Occupation \_\_\_\_\_

Exercise Level? \_\_\_ No Exercise \_\_\_ 1-2 Times A Week \_\_\_ 3+ Times A Week

Do you use tobacco? Yes / No \_\_\_ Quit - how many years? \_\_\_\_\_

Tobacco Product \_\_\_ Cigarette \_\_\_ Smokeless Tobacco \_\_\_ Cigars

Average your smoke per day? \_\_\_ 1/2 pack \_\_\_ 1 pack \_\_\_ 1 1/2 pack \_\_\_ 2 packs \_\_\_ 3 packs

Do you drink alcohol? Yes / No # of days per week \_\_\_\_\_ # drinks per week \_\_\_\_\_

**REVIEW OF SYSEMS**

Do you experience any of the following? (Check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Weight loss/gain       | <input type="checkbox"/> Fatigue/weakness         | <input type="checkbox"/> Fever/chills        |
| <input type="checkbox"/> Night sweats           | <input type="checkbox"/> Migraine headaches       | <input type="checkbox"/> Visual changes      |
| <input type="checkbox"/> Glasses/contact lenses | <input type="checkbox"/> Hearing loss             | <input type="checkbox"/> Vertigo             |
| <input type="checkbox"/> Nausea/vomiting        | <input type="checkbox"/> Tinnitus/ringing in ears | <input type="checkbox"/> Nosebleeds          |
| <input type="checkbox"/> Bleeding gums          | <input type="checkbox"/> Dental pain/cavities     | <input type="checkbox"/> Hoarseness          |
| <input type="checkbox"/> Sore throat            | <input type="checkbox"/> Shortness of breath      | <input type="checkbox"/> Cough               |
| <input type="checkbox"/> Wheezing               | <input type="checkbox"/> Coughing of blood        | <input type="checkbox"/> Angina/chest pain   |
| <input type="checkbox"/> Heart murmur           | <input type="checkbox"/> Pacemaker                | <input type="checkbox"/> Heartburn/reflux    |
| <input type="checkbox"/> Diarrhea/constipation  | <input type="checkbox"/> Abdominal pain           | <input type="checkbox"/> Jaundice            |
| <input type="checkbox"/> Bloody stool           | <input type="checkbox"/> Frequent Urination       | <input type="checkbox"/> Pain with urination |
| <input type="checkbox"/> Kidney Stones          | <input type="checkbox"/> Blood clots/DVT/PE       | <input type="checkbox"/> Varicose veins      |
| <input type="checkbox"/> Easy bruising/bleeding | <input type="checkbox"/> Memory loss              | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Paralysis              | <input type="checkbox"/> Depression/anxiety       |  |

Patient Signature: \_\_\_\_\_