Lexington Orthopaedics and Sports Medicine

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Patient Information Intake Form

Date:_____ Name:_____ Date of Birth:_____ Age:_____

Height:_____ Weight:_____ Sex: ☐ Male ☐ Female Which is your dominate hand: ☐ Left ☐ Right

What doctor sent you to us:_____ Family Physician:_____

Current Employer:_____ Occupation:_____ Retired: ☐ Yes ☐ No

Chief complaint/reason for visit:_____

Which body part is the reason for your visit today? _____ This pain is: ☐ New ☐ Recurrent ☐ Chronic

Have you had any past surgeries related to the body part listed above? ☐ Yes ☐ No

Have you had any of the following diagnostic tests in relation to today's reason for visit?

☐ MRI ☐ CT ☐ Ultrasound ☐ EMG ☐ Indium Scan ☐ Other:_____

Is today's visit due to an injury? ☐ Yes ☐ No Date of onset/Injury:_____

If there is an injury, what type of injury?

☐ Motor vehicle accident ☐ Fall from standing height ☐ Fall from high structure ☐ An altercation ☐ A direct blow

☐ Caught in machinery ☐ Athletic Injury ☐ Other (Specify_____) ☐ N/A

Where did the injury occur?

☐ At the gym ☐ At a nursing home ☐ At the pool ☐ In the street ☐ In the yard ☐ At home

☐ At the park ☐ At school ☐ At work ☐ Other (Specify_____)

Quality of pain: ☐ Aching ☐ Cramping ☐ Burning ☐ Shooting ☐ Stabbing

Severity of pain: ☐ No Pain (0) ☐ Mild (1-3) ☐ Moderate (4-6) ☐ Severe (7-10)

Frequency of pain: ☐ Constantly ☐ 2-4 times/day ☐ Daily ☐ Every several days ☐ Intermittently ☐ Rarely

Progression of pain since onset:

☐ Unchanged ☐ Resolved ☐ Gradually improving ☐ Rapidly improving ☐ Gradually worsening ☐ Rapidly worsening ☐ Waxing and waning

Pain is aggravated by (check all that apply): ☐ Nothing ☐ Movement ☐ Palpation ☐ Use ☐ Weight bearing

Treatments tried to help pain (check all that apply):

☐ Nothing ☐ Elevation ☐ Ice ☐ Non-weight bearing ☐ Rest ☐ Tylenol® ☐ Anti-inflammatory medications

☐ Immobilization ☐ Injections ☐ Heat ☐ Physical Therapy ☐ Boot or Cast ☐ Brace/Orthotic/Assistive device

Improvement with treatment (check one): ☐ No relief ☐ Mild ☐ Moderate ☐ Significant

Treatments tried (check all that apply): ☐ Physical Therapy ☐ Injection(s) ☐ Medication

CONTINUED ON BACK

Review of Systems (check any of the following that you are currently experiencing)

Constitutional
☐ Fever
☐ Chills
☐ Sweats

HENT
☐ Facial swelling
☐ Nosebleeds

Eyes
☐ Visual disturbance

Respiratory
☐ Shortness of breath
☐ Chest tightness

Cardiovascular
☐ Chest pain
☐ Leg swelling

Gastrointestinal
☐ Blood In stool
☐ Constipation
☐ Diarrhea

Genitourinary
☐ Difficulty urinating
☐ Dysuria (Pain when urinating)
☐ Flank pain
☐ Blood in urine

Musculoskeletal
☐ Joint pain
☐ Back pain
☐ Difficulty walking
☐ Joint swelling
☐ Muscle pain
☐ Neck pain

Neurological
☐ Dizziness
☐ Headaches
☐ Numbness
☐ Limb/muscle weakness

Hematologic
☐ Bruising
☐ Easy Bleeding

Psychological
☐ Confusion
☐ Nervous/anxious
☐ Self-inflicted injury

Skin
☐ Change in color
☐ Rash/lesions
☐ Open wound

Medical History (check all that apply)

☐ Alcoholism
☐ Anxiety
☐ Asthma
☐ Cancer
☐ COPD/emphysema
☐ Depression
☐ Diabetes
☐ DVT/PE/blood clots
☐ Gout
☐ Heart disease
☐ Hepatitis
☐ HIV/AIDS
☐ High blood pressure
☐ Kidney disease
☐ Malignant hyperthermia
☐ Osteoporosis
☐ Peripheral vascular disease (Poor circulation)
☐ Stroke
☐ Substance abuse
☐ Ulcers
☐ No significant history

Surgical History (check all that apply)

☐ Tonsils/adenoids
☐ Appendectomy
☐ Biopsy (_____)
☐ Brain surgery
☐ Breast surgery
☐ Heart bypass (CABG)
☐ Gall bladder removal
☐ Colon surgery
☐ Cosmetic surgery
☐ Eye surgery
☐ Fracture surgery
☐ Gastric bypass/banding
☐ Hernia repair
☐ Hip surgery
☐ Hysterectomy
☐ Knee surgery
☐ Kidney stones (lithotripsy)
☐ Ovary removal
☐ Prostate surgery
☐ Spine surgery
☐ Valve replacement
☐ Vasectomy
☐ None
☐ Other:_____

Family Medical History (check all that apply)

Relationship	Living/Deceased	COPD	Heart disease	Hepatitis	Diabetes	Ulcers	Gout	HIV	Depression	Anxiety disorder	Kidney disease	Fibromyalgia	Osteoporosis	Peripheral vascular	Deep vein thrombosis	Stroke	Drug abuse	Alcohol abuse
Mother																		
Father																		
Sister																		
Brother																		

Social History

Marital status

☐ Married ☐ Widowed ☐ Single ☐ Divorced

Do you drink alcohol ☐ Yes ☐ No

Glasses of wine per week_____

Cans of beer per week_____

Shots of liquor per week_____

Smoking status

☐ Current smoker ☐ Former smoker ☐ Never smoked

_____ Packs per day for _____years

Are you pregnant? ☐ Yes ☐ No

CONTINUED ON NEXT PAGE

Current Medications List medication, dose & frequency. For example: Aspirin, 325mg, twice a day

Medication	Dose	Frequency

Medical Allergies List all medical allergies and reactions they cause.

Medical Allergy	Reaction
☐ Latex	
☐ Betadine	
☐ Nickle	