

PATIENT INTAKE SHEET

Date _____

Name: _____ Sex: M/F Date of Birth _____ Age _____

Visit: New Follow-up ER follow-up (Date in ER _____) Hand dominance _____

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 Number of injections _____ 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

How did you learn about Makefield Orthopaedics?

Referred by physician: Dr. _____ Radio Word of Mouth Internet

Newsletter/direct mail Newspaper Yellow Pages Other _____

Complications from surgery or anesthesia? _____

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 Other _____

Current Work Status: Employed Unemployed On Disability: As of Date _____

Homemaker Full Time Part Time Occupation: _____

Do you Smoke? Yes No How long have you smoked? _____ How much do you smoke? _____

Do you drink alcohol? Yes No How Much? _____

Height: _____ Weight: _____

BRIEFLY ANSWER THE FOLLOWING QUESTIONS AS BEST YOU CAN (IF NONE, ANSWER "NONE")

Surgeries: _____

Chronic Illnesses: _____

Medications: _____

Drug Allergies: _____

Are you taking any herbal (or non-prescription medications)? _____

Reviewed By: _____

PATIENT'S SIGNATURE