MAIN LINE ORTHOPAEDICS, P.C.
INTAKE FORM

NAME _____ **APPOINTMENT DATE** _____

Chief Complaint: (What is the problem? Example: right knee pain, left shoulder pain, arthritis, etc):

_____

_____

History: (How and when did your problem begin?)

_____

_____

Please indicate any treatments you have had so far: (Check all that apply)

____None ____Injections ____Physical Therapy (how long and where) _____

____Surgery (when and where) _____

____Medications (for this problem) _____

Please categorize your pain: (Please circle one) none mild mild to moderate
moderate moderate to severe severe unbearable

My pain is: (Please circle all that apply) constant intermittent achy burning
deep superficial improving worsening

Modifying factors (What makes your pain better or worse? Please check all that apply)

____Better with activity ____Worse with activity ____Better with rest ____Worse with rest

____Better with sleep ____Worse with sleep ____better with medicines ____Nothing

____Changing positions help (describe):_____

Past Medical History (Please check all that apply): ____**NEGATIVE**

____arthritis	____fibromyalgia	____gout	____hearing loss	____stroke
____coronary disease	____heart attack	____arrhythmia	____asthma	____COPD
____high blood pressure	____GERD	____ulcers	____thyroid disease	____hepatitis
____cancer	____anemia	____diabetes	____colitis	____neuropathy
____excessive bleeding	____DVT (clots)	____osteoporosis	____pulmonary embolism	

Past Surgical History (Please list any prior surgeries and approximate dates): _____**NEGATIVE**

_____

_____

If you have had surgery, have you had any problems with anesthesia? Please explain:_____

Do you have any of the following problems? (Please check all that apply) ____**NONE**

____abdominal pains
____balance/dizziness problems
____blurred vision
____body aches
____burning with urination
____chest pains or tightness
____chills/fever
____chronic cough
____constipation/diarrhea
____depression
____difficulty with urination
____headache
____hearing loss
____heart palpitations
____heartburn (reflux)
____mood swings
____nausea or vomiting
____pain in multiple joints
____recent weight gain or loss
____shortness of breath
____skin bruising
____skin rashes
____sore or dry throat
____swelling in arms or legs

Family History (Does anyone in your family have a history of the following?) Please check all that apply:

____arthritis	____stroke	____osteoporosis	____hearing loss	____mult. fractures
____coronary disease	____heart attack	____arrhythmia	____asthma	____COPD
____high blood pressure	____GERD	____ulcers	____thyroid disease	____hepatitis
____cancer	____anemia	____diabetes	____colitis	____neuropathy
____substance abuse	____DVT (clots)	____pulmonary embolism	____anesthesia problems	

Social History: (Please check the appropriate space):

Smoking History ____none ____less than one pk/day ____one pk/day ____two pks/day
____more than two pks/day ____prior smoker who quit…when?_____

Alcohol Use ____none ____socially ____daily.
If daily how much and what do you drink_____

Recreational Drugs Please list any recreational drug use_____

History of substance abuse? ____No ____Yes. Explain_____

Drug Allergies (Please check or list others): ____**NONE**

____penicillin ____keflex or cephalosporins ____sulfa ____IVP dye

____aspirin Others:_____

Metal Allergies: Yes or No

Current Medications (**PRINT CLEARLY** and list all medications or supply us with a separate list): ____**NONE**

_____

_____

_____

Please list your height and weight: **Height**_____ **Weight**_____

DO NOT WRITE BELOW THIS LINE

Notes: (for office use only):_____

_____

_____

_____