St. Peter's Medical Group
Orthopaedics

Orthopedic New Patient Intake Form

History of Present Illness

Date: ________________

Name: ________________________________ Date of Birth: ___________ □ Male □ Female
Primary Care Physician: ___________________
Marital Status: □ Married □ Single □ Widowed □ Divorced □ Life partner
Did your doctor refer you here? □Yes □No Referring Physician: _______________________
Name of Employer: ___________________ Occupation: ______________________
Is this a work related Injury? □Yes □No

Have you had x-rays, MRI, CT or other tests for this problem? □Yes □ No
Do you have them with you? □ Yes □ No
Have you been to the Emergency Room for this problem? □ Yes □ No
If yes: Date seen: ___________________ Which Emergency Room? __________________

Preferred Communication: □Written □ Visual □ Sign Language □ No preference
Primary Language: □ English □ Other _______________ Interpreter Needed □ Yes □ No
Barriers to Learning?____

Chief Complaint

Reason you are being seen today: ____
Which side of your body is injured: □ Right □ Left □ Bilateral
Where is your pain or problem? ____
When did it start? ____
Is it: □ Sharp □ Burning □ Dull □ Aching □ Throbbing
Is it □ Mild □ Moderate □ Severe
When does it occur? □Morning □Night □Constant □After Exercise □ During Exercise □ Intermittent
Has it: □Improved □Stayed the same □Worsened
Describe what makes it better: ____
Describe what makes it worse: ____
Do you have any of the following: □Swelling □Numbness □Bruising □Tingling

Medications, Supplements, & Vitamins You Currently Take (List dosage and how often)

____

____

Medication Allergies (Please also list reaction if known)

____

Do you smoke? □Yes □ No □Quit If yes, how much? _______________ How many years? _________________

Do you drink alcohol? □Yes □ No □Quit If yes, how much/often? _______________________

Do you have a cardiologist? □ Yes □No Who:____

Are you: □Right Handed □Left Handed □Ambidextrous □Unknown at this time

Continued on Back

Comprehensive History

Review of Systems: What are you experiencing today?

- □ Fatigue
- □ Fever
- □ Night Sweats
- □ Weight Gain
- □ Weight Loss
- □ Difficulty Swallowing
- □ Hoarseness
- □ Chest Pain
- □ Irregular Heart Beat
- □ Fainting
- □ Leg Ulcers
- □ Swelling in hands
- □ Swelling in feet
- □ Nausea
- □ Vomiting
- □ Heartburn
- □ Change in bowel habits
- □ Constipation
- □ Diarrhea
- □ GERD
- □ Incontinence
- □ Bladder Infection
- □ Urinary Frequency
- □ Urinary Urgency
- □ Back Pain
- □ Joint Pain
- □ Joint Swelling
- □ Muscle Aches
- □ Muscle Weakness
- □ Stiffness
- □ Neck Pain
- □ Leg Pain
- □ Muscle Spasm
- □ Gout
- □ Groin Pain
- □ Hair Changes
- □ Changes in Moles
- □ Skin Changes
- □ Itchiness
- □ Rash
- □ Bruises
- □ Bleeding
- □ Limping
- □ Headache
- □ Migraine
- □ Numbness
- □ Tingling
- □ Seizures
- □ Slurred Speech
- □ Frequent Falls
- □ Confusion
- □ Dropping Things Frequently
- □ Depression
- □ Anxiety
- □ Mental Illness
- □ Anemia
- □ Other___________

<u>Past Medical History</u>

- □ Hypertension
- □ Diabetes
- □ Kidney Disease
- □ Stroke
- □ Arthritis
- □ Previous Blood Clot
- □ Asthma
- □ Seizure Disorder
- □ Thyroid Disease
- □ Coronary Artery Disease
- □ Gout
- □ Blood Disorders
- □ Arrhythmia
- □ Hepatitis
- □ High Cholesterol
- □ Ulcers
- □ Skin Infection
- □ Joint Infection
- □ Bladder Infections
- □ MRSA
- □ Sleep Apnea/CPAP
- □ Fractures
- □ Osteoporosis
- □ Substance Abuse
- □ Alcoholism
- □ Multiple Sclerosis
- □ HIV
- □ AIDS
- □ Past Blood Transfusions
- □ Cancer(type) _______________
- □ Mental Illness
- □ Other:______________________

<u>Previous Surgery(s), Include Dates</u>

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<u>Family History</u> Does anyone in your family have any of the following? ***<u>Please list relative next to disorder</u>***

- □ Diabetes
- □ Thyroid Disease
- □ Asthma
- □ High Cholesterol
- □ High Blood Pressure
- □ Heart Disease
- □ Kidney Disease
- □ Stroke
- □ Blood Clots
- □ Epilepsy/Seizures
- □ Congestive Heart Failure
- □ Alcoholism
- □ Depression
- □ Substance Abuse
- □ Osteoporosis
- □ Cancer (type) _______________
- □ Other: ______________________

This form was filled out by: □ Patient □ Parent/Guardian □ Significant Other □ Other

Signature: ____

□ Information Entered in EMR