Eastside Orthopedics & Sports Medicine
Medical History Intake Form

Date:

PLEASE PRINT ALL INFORMATION

NAME: **DOB:**

What is your approximate weight? lbs | Height? ft in

Referred here by: (circle one) Self Family Friend Doctor Attorney Other

Name of Person/ Physician making referral:

List Current Treating Physicians including PCP: Phone number:

Describe the reason for your visit:

Body part to be examined: Right Left Both

How did your symptoms/injury begin? (describe in detail please)

Approximate date symptoms began or date of injury: New or Old injury (circle one)

On a scale of 1-10 (10 being most severe) circle the # that best describes your pain: 1 2 3 4 5 6 7 8 9 10

Resulting from: (circle which applies) Sports Accident Work Related Litigation

Are Symptoms: Constant Intermittent Worsening Improving Unchanged

Circle all that apply: Pain Stiffness Swelling Instability Weakness Numbness/tingling

What makes symptoms worse?

What makes symptoms better?

What previous form of treatment have you had for this problem? (Medications, therapy, surgery, injections)

**** DO YOU HAVE ANY DRUG ALLERGIES? ** (circle one) YES NO**

If yes, name the drug and describe the reaction, please be specific. (Example: rash, nausea, shortness of breath, etc)

CURRENT MEDICATIONS:

NAME OF DRUG	REASON FOR USE	DOSAGE INSTRUCTIONS
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PREFERRED PHARMACY NAME: PHONE NUMBER:

ADDRESS:

PAST SURGICAL HISTORY

Previous Type of Operation- Please include year performed

1.	5.
2.	6.
3.	7.
4.	8.

Any previous fractures? YES ☐ NO ☐ Body part?

Name:_____ Date:_____

SOCIAL HISTORY

	YES	NO	
Do you currently smoke?	☐	☐	Amount per day: _____
Have you ever smoked?	☐	☐	Year you quit: _____
Use chewing tobacco?	☐	☐	How much: _____
Use smokeless tobacco?	☐	☐	
Do you consume alcohol?	☐	☐	How many:_____ History of Abuse: ☐YES ☐NO
Have you ever had a problem with drug use?	☐	☐	Past ☐ Current ☐
Do you participate in recreational drug use?	☐	☐	If yes, or in the past, list type and amount:
Have you ever used intravenous drugs?	☐	☐	Past ☐ Current ☐

Marital Status (please circle) Single Married Widowed Divorced Children: YES ☐ NO ☐ How many:___

Please list all sports and hobbies you are involved in:_____

REVIEW OF SYSTEMS (Do you currently have or had a history of the following? Please check all that apply)

GENERAL
- ☐ Recent weight gain/loss
- ☐ Cancer? Type? _____
- ☐ Thyroid problems
- ☐ Fevers
- ☐ Right handed ☐ Left handed

EYE, EAR & THROAT
- ☐ Glasses
- ☐ Contacts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Nosebleeds
- ☐ Dizziness due to inner ear
- ☐ Hay fever
- ☐ Hearing Loss
- ☐ Dentures
- ☐ Tonsillitis
- ☐ Sleep Apnea

RESPIRATORY
- ☐ Productive cough
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma or Lung Disease
- ☐ Tuberculosis

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Heart attack
- ☐ High cholesterol
- ☐ Irregular heartbeat
- ☐ Pacemaker
- ☐ Heart surgery
- ☐ Congestive Heart Failure

GASTROINTESTINAL
- ☐ Hernia
- ☐ Peptic Ulcer
- ☐ Indigestion/ heartburn
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Pancreatitis
- ☐ Diverticulitis
- ☐ Colitis
- ☐ Diabetes
  Type I ☐ Type II ☐
- ☐ Kidney Disease

BLOODBORNE PATHOGENS
- ☐ HIV / AIDS
- ☐ Hepatitis
- ☐ Other

UROLOGIC/REPRODUCTIVE
- ☐ Frequent urination
- ☐ Difficulty urinating
- ☐ Urinary incontinence
- ☐ Prostate problems
- ☐ Currently Pregnant
- ☐ Post Menopausal

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Joint Swelling
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Bone/ Joint Infections
- ☐ Gout
- ☐ Low back/ sciatica pain
- ☐ Fibromyalgia
- ☐ Weakness

SITES OF INFECTION
- ☐ Urinary
- ☐ Dental
- ☐ Previous surgery
- ☐ MRSA

NEUROLOGICAL/ PSYCHIATRIC
- ☐ Headaches
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Loss of Consciousness
- ☐ Numbness or Tingling
- ☐ Blindness
- ☐ Anxiety
- ☐ Depression
- ☐ Seizure
- ☐ Tremors
- ☐ Stroke
- ☐ Psychiatric Treatment

DERMATOLOGIC
- ☐ Rash
- ☐ Unhealing Ulcers

HEMATOLOGIC
- ☐ Anemia
- ☐ Blood Clots/ DVT
- ☐ Bleeding Tendency
- ☐ Easily Bruised
- ☐ Circulatory Problems
- ☐ Anticoagulation
- ☐ Phlebitis
- ☐ Hemophilia

FAMILY HISTORY

Please check if any of your family(parents, brothers, sisters, grandparents) have a history of the following:
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Anesthetic Complications
- ☐ Cancer? Type? _____
- ☐ Abnormal Bleed Tendencies
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Gout

I, as the patient, state the information is correct and accurate to the best of my knowledge.

Patient Signature: _____ **Physician Signature:** _____