DocCare®

AMB MEDICAL SERVICES, P.C.

# ORTHOPEDIC INTAKE FORM *PLEASE PRINT*

## *HISTORY OF PRESENT ILLNESS/INJURY*

| | |
|---|---|
| PATIENT NAME: | |
| DATE OF BIRTH: | |
| LOCATION OF THE PROBLEM (PLEASE CIRCLE) | NECK BACK |
| ➢ UPPER EXTREMITY (PLEASE CIRCLE) | ARM SHOULDER ELBOW WRIST HAND |
| ➢ LOWER EXTREMITY (PLEASE CIRCLE) | HIP KNEE ANKLE FOOT TOES |
| ON A SCALE OF 1 TO 1O *(10 BEING THE MOST SEVERE)* PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN: | 1 2 3 4 5 6 7 8 9 10 |
| WHEN DID YOU FIRST NOTICE THE PROBLEM? | _____DAYS AGO _____WEEKS AGO<br>_____MONTHS AGO _____YEARS AGO |
| DOES ANYTHING HELP OR MAKE THE PROBLEM WORSE?<br>(PLEASE CIRCLE WHAT APPLYS TO YOU) | MOVING AROUND STANDING UP<br>LYING ON MY SIDE<br>OTHER: _____ |
| HOW LONG DOES THE PROBLEM LAST? | 30 MINUTES ONE HOUR<br>IT IS ALWAYS THERE<br>OTHER: _____ |
| IS ANYTHING ELSE OCCURING AT THE SAME TIME? | NO<br>YES (PLEASE EXPLAIN) _____ |
| DO YOU EXPERIENCE NUMBNESS OR TINGLING? | YES NO |
| DESCRIBE THE INTENSITY OF THE PROBLEM | DULL THEN SHARP ☐<br>VERY SHARP THEN IT LEAVES ☐<br>ALWAYS THERE ☐<br>OTHER: _____ |
| DOES THE PROBLEM INTERFERE WITH YOUR NORMAL FUNCTIONS? | NO<br>YES (PLEASE EXPLAIN)_____ |

## PAST MEDICAL AND SOCIAL HISTORY:

LIST ALL THE CURRENT SERIOUS ILLNESSES:

_____

_____

LIST ALL PAST SERIOUS ILLNESSES AND OR SURGERIES, AND WHEN THEY OCCURRED:

_____

_____

DO YOU SMOKE? _____ HOW MUCH? _____

DO YOU DRINK? _____ HOW MUCH? _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY ON:

_____

ARE YOU ON A SPECIAL IDET? NO YES (PLEASE EXPLAIN) _____

DO YOU HAVE ANY ALLERGIES? NO YES (PLEASE EXPLAIN) _____

WHAT IS YOUR OCCUPATION? _____

FAMILY HISTORY SUCH AS HEART DISEASE, DIABETERS, TUBERCULOSIS, CANCER, ETC.:

_____

| **CONSTITUTIONAL** | | | **GASTROINTESTINAL** | | | **EAR/NOSE/THROAT** | | |
|---|---|---|---|---|---|---|---|---|
| FEVER | Y | N | ABDOMINAL PAIN | Y | N | EAR INFECTION | Y | N |
| CHILLS | Y | N | NAUSEA/VOMITING | Y | N | SORE THROAT | Y | N |
| HEADACHE | Y | N | ULCER | Y | N | SINUS PROBLEM | Y | N |
| **OTHER** | | | INDIGESTION | Y | N | **OTHER:** | | |
| | | | HEARTBURN | Y | N | | | |
| | | | **OTHER:** | | | | | |

| **EYES** | | | **GYNECOLOGY** | | | **GENITOURINARY** | | |
|---|---|---|---|---|---|---|---|---|
| BLURRED VISION | Y | N | PREGNANCIES | Y | N | URINE RETENTION | Y | N |
| DOUBLE VISION | Y | N | INFECTION | Y | N | PAINFUL URINATION | Y | N |
| PAIN | Y | N | MENOPAUSE | Y | N | URINARY FREQUENCY | Y | N |
| CATARACT | Y | N | **OTHER:** | | | **OTHER:** | | |
| **OTHER:** | | | | | | | | |

| **ALLERGIC** | | | **CARDIOVASCULAR** | | | **RESPIRATORY** | | |
|---|---|---|---|---|---|---|---|---|
| HAY FEVER | Y | N | CHEST PAIN | Y | N | WHEEZING | Y | N |
| DRUG ALLERGIES | Y | N | VARICOSE VEINS | Y | N | FREQUENT COUGH | Y | N |
| **OTHER:** | | | HIGH BLOOD PRESSURE | Y | N | SHORTNESS OF BREATH | Y | N |
| | | | PALPITATION/ARRHYTHMIA | Y | N | ASTHMA | Y | N |
| | | | **OTHER:** | | | **OTHER:** | | |

| **NEUROLOGICAL** | | | **INTEGUMENTARY** | | | **HEMATOLOGY/LYMPHATIC** | | |
|---|---|---|---|---|---|---|---|---|
| TREMORS | Y | N | SKIN RASH | Y | N | SWOLLEN GLANDS | Y | N |
| DIZZY SPELLS | Y | N | BOILS | Y | N | BLOOD CLOTTING | Y | N |
| NUMBNESS/TINGLING | Y | N | PERSISTENT ITCH | Y | N | LEUKEMIA/LYMPHOMA | Y | N |
| **OTHER:** | | | **OTHER:** | | | CANCER | Y | N |
| | | | | | | **OTHER:** | | |

| **ENDOCRINE** | | | **MUSCULOSKELATAL** | | | **PSYCHOLOGICAL** | | |
|---|---|---|---|---|---|---|---|---|
| EXCESSIVE THIRST | Y | N | JOINT PAIN/ARTHRITIS | Y | N | ANXIETY | Y | N |
| TOO HOT/ TOO COLD | Y | N | NECK PAIN | Y | N | SEVERELY DEPRESSED | Y | N |

| | | |
|---|---|---|
| TIRED/SLUGGISH Y N | BACK PAIN Y N | CONSIDERED SUICIDE Y N |
| DIABETES Y N | **OTHER:** | **OTHER:** |
| **OTHER:** | | |
| | | |
| **VITAL SIGNS:** | **DRUGS TAKEN:** | **SURGICAL HISTORY:** |
| **HEIGHT:** | | |
| **WEIGHT:** | | |
| **PULSE:** | | |
| **TEMPERATURE:** | | |
| **BLOOD PRESSURE:** | | |
| **ALLERGIES:** | | |
| | | |

| | |
|---|---|
| ***PATIENT SIGNATURE*** | |
| ***PHYSICIAN SIGNATURE*** | |