NEW WEST SPORTS MEDICINE & ORTHOPAEDIC SURGERY, PC
PATIENT INTAKE AND HISTORY FORM

(Please print)

Name: _____ **Date of Birth:** _____

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ African-American ☐ More Than One Race
☐ Native Hawaiian ☐ Other Pacific Islander ☐ Caucasian ☐ Refused to Report/Unreported
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to Report/Unreported
Language: ☐ English ☐ Spanish ☐ Other: _____
Pharmacy: _____
(Name/City/Phone #)

Do you use a mail order pharmacy? _____ If so, please be sure we have your pharmacy provider information and a copy of your prescription drug card.

Mail Order Pharmacy: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____
Timing/Onset:
When did symptoms first occur? _____
Duration:
Frequency of symptoms? _____
Characterized as/Severity:
Describe the severity of the symptoms/pain. _____
Associated Signs and Symptoms:
Are there any other symptoms associated with your problem? _____
Modifying Factors:
What makes the condition better/worse? _____

Have you been treated for this condition by any other provider? If yes, please name. _____

Problem List/Past Medical History:

Have you been diagnosed with any of the following (currently or in the past)?

☐ Alcoholism	☐ Diabetes	☐ Osteoporosis
☐ Arthritis	☐ Fibromyalgia	☐ Parkinson's Disease
☐ Asthma	☐ GERD (Reflux Disease)	☐ Seizures
☐ Bleeding Disorder	☐ Gout	☐ Sleep Apnea
☐ Blood Clot	☐ Heart Disease	☐ Thyroid Disorder
☐ Cancer	☐ High Blood Pressure	☐ Wound Infection
☐ COPD	☐ High Cholesterol	
☐ Depression	☐ Kidney Disease	

List any other important medical condition(s) you have had (do not include common colds or flu). Include date of initial diagnosis if possible.

Problem/Previous Diagnosis *Date(s) or Age*

_____
_____

PAST SURGICAL HISTORY:

☐ I have not had any surgeries in the past.

Place an "X" next to any past surgical procedure you have had, and circle Left (L) or Right(R) if applicable:

			Date(s) or Age	Surgeon
☐ Ankle Surgery	☐ L	☐ R		
☐ Hand Surgery	☐ L	☐ R		
☐ Carpal Tunnel Surgery	☐ L	☐ R		
☐ Arthroscopic Knee Surgery	☐ L	☐ R		
☐ Total Knee Replacement	☐ L	☐ R		
☐ Total Hip Replacement	☐ L	☐ R		
☐ Arthroscopic Shoulder Surgery	☐ L	☐ R		
☐ Total Shoulder Replacement	☐ L	☐ R		
☐ Spinal Fusion				
☐ Discectomy				

☐ Appendectomy ☐ Hysterectomy ☐ Prostatectomy

☐ Hernia Repair ☐ Cesarean section ☐ Mastectomy ☐ L ☐ R

☐ Heart Surgery ☐ Cholecystectomy

Other (Surgery(s), Date/Age, & Surgeon): _____

_____

_____

ALLERGY HISTORY:

☐ **None** ☐ **NKDA (No Known Drug Allergies)**

☐ Anesthesia ☐ Iodine ☐ Penicillin ☐ Sulfa Drugs ☐ Adhesive Tape

☐ Contrast Dye ☐ Latex ☐ Shellfish ☐ Other: _____

MEDICATION HISTORY:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, and herbs that you are currently taking:

Name of Medication	Dosage	Name of Medication	Dosage

FAMILY HISTORY

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
HIV Infection	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐

List any other important family medical condition(s) you are aware of (do not include common colds or flu). Include date of initial diagnosis if possible:

Family Member *Medical Condition / Date of Initial Diagnosis*

_____

_____

_____

Have you or anyone in your family(mother, father, sister, brother) ever had a reaction to anesthetic, general or local, causing high fever(malignant hyperthermia), blood pressure problems, hepatitis or any other type of allergic reaction?
Yes ☐ No ☐ If yes, please explain: _____

SOCIAL HISTORY:

What is your most recent occupation? _____Job Title:_____

Business Name: _____ Address:_____

Please describe your current tobacco use: ☐ Never Smoker ☐ Former Smoker ☐ Current every day smoker ☐ Current some day smoker ☐ Current status unknown ☐ Unknown if ever smoked

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? ☐ Yes ☐ No

If yes, please indicate what type of drug and how often:_____

Please describe your highest education level attained?

☐ Less than high school ☐ High school graduate ☐ Some college ☐ College graduate ☐ Postgraduate ☐ Unknown

Please describe your current exercise routine: ☐ Inactive ☐ Light ☐ Moderate ☐ Vigorous

If you do have a current exercise routine, how many times per week: _____

Please describe your hobbies and interests?_____

_____

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General:
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats

Skin:
- ☐ Rash
- ☐ New Lesions

HEENT:
- ☐ Headache
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Hearing Loss

Neck:
- ☐ Neck Mass
- ☐ Swollen Glands

Respiratory:
- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty Breathing

Cardiovascular:
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Palpitations

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation

Male Genitourinary:
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence

Female Genitourinary:
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence

Musculoskeletal:
- ☐ Muscle Weakness
- ☐ Muscle Atrophy
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Joint Pain

Neurological:
- ☐ Tingling
- ☐ Numbness
- ☐ Seizures
- ☐ Stroke

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Easily Irritated

Endocrine/Glands:
- ☐ Thyroid Problems

Hematology:
- ☐ Anemia
- ☐ Blood Clots
- ☐ Easy Bruising
- ☐ Easy Bleeding