

Date: _____



Minnesota Orthopaedic Specialists

Patient Intake Form

Patient Name: _____ Birth date: _____

Who referred you for this visit? _____

Primary Care Doctor and Clinic: _____

Estimated date of injury or onset of problem: _____

Is this work related? Yes No Motor vehicle accident? Yes No

Dominant hand: Left hand Right hand Ambidextrous

Part of body being seen for today: _____ Which side: Left Right Both

► Social History:

Marital Status: Married Single Widowed Divorced Separated Domestic Partnered

Number of Children: _____ Their ages: _____

Living Arrangements: House Townhouse Apartment or Condo Care Facility Other

Education: Grade school Some HS HS Graduate Some college/Tech school College Grad Post Grad

Employment Status: Currently Employed Unemployed Disabled Retired Student

Place of Employment: _____ Hours Per Week: 0-10 10-20 20-30 30-40 40+

Occupation and Responsibilities: _____

Hobbies and Recreational Activities (Sports, Music/Arts, Crafts): _____

Do you smoke or use tobacco products? Yes No If so, are you interested in a cessation program? Yes No

Do you drink alcohol? Yes No If so, how many drinks per week? 0 1-6 7-13 14+

Have you ever been treated for substance abuse or used illegal drugs? Yes No

► Drug Allergies: _____

Do you have an allergy to tape or adhesives? Yes No Do you have an allergy to latex? Yes No

► Fall Assessment:

Are you 65 years of age or older? Yes No Have you fallen in the past year? Yes No

If so, did it result in an injury? Yes No Have you fallen 2 times in the last year? Yes No

► Review of Symptoms: Indicate any of the following symptoms you have had in the past 6 months:

Const: None Fatigue Fever Night sweats Weight gain Weight loss

Cardio: None Chest Pain/Pressure Heart Palpitations (Skipped Beats)

Skin: None Cellulitis Keloid Psoriasis Rash Redness Sores Warmth

Endo: None Excessive Thirst Obesity

GI: None Abdominal Pain Constipation Diarrhea Heartburn Nausea Vomiting

GU: None Kidney Failure Pregnancy

Hema: None Bleeding Blood Clots Bruising

MS: None Back Pain Bone Pain Decreased Range of Motion Joint Locking Joint Pain(s)

Muscle Pain(s) Muscle Weakness Neck Pain Osteoporosis Shooting Pain Swelling

Neuro: None Gait Abnormality Numbness and Tingling

Psych: None Alcohol Abuse Anxiety Depression Drug Abuse Stress

Resp: None Emphysema Shortness of Breath Wheezing

► Indicate any tests or treatments that you have had for this condition (include location and year):

- Injection _____ Surgery _____
 X-rays _____ MRI _____
 CT/CAT Scans _____ EMG _____
 Physical Therapy _____ Other _____

► Other Medical Problems for which you are or have been treated:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Gastro Reflux	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Cellulitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Lupus	<input type="checkbox"/> Seizures
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Deep Vein Thrombosis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> MS	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Keloid	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Other _____

► List any previous surgeries and note the year they were performed to the right:

<input type="checkbox"/> None	<input type="checkbox"/> Breast _____	<input type="checkbox"/> Foot _____	<input type="checkbox"/> Knee _____	<input type="checkbox"/> Tonsillectomy _____
<input type="checkbox"/> Abdominal _____	<input type="checkbox"/> Cardiac _____	<input type="checkbox"/> Gall Bladder _____	<input type="checkbox"/> Nasal _____	<input type="checkbox"/> Vascular _____
<input type="checkbox"/> Ankle _____	<input type="checkbox"/> Ear _____	<input type="checkbox"/> Hand _____	<input type="checkbox"/> Ovary _____	<input type="checkbox"/> Wrist _____
<input type="checkbox"/> Appendectomy _____	<input type="checkbox"/> Elbow _____	<input type="checkbox"/> Hip _____	<input type="checkbox"/> Prostate _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Back _____	<input type="checkbox"/> Eye _____	<input type="checkbox"/> Hysterectomy _____	<input type="checkbox"/> Shoulder _____	Year _____
<input type="checkbox"/> Bladder _____	<input type="checkbox"/> Facial _____	<input type="checkbox"/> Jaw _____	<input type="checkbox"/> Throat _____	

► Indicate primary family members (parent, brother, sister or child) with any of the following conditions:

	Primary Relative		Primary Relative
Alcoholism	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	Lupus	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>
Cardiovascular Disease	<input type="checkbox"/>	MS	<input type="checkbox"/>
Cerebrovascular Disease	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>
Degenerative Joint Disease	<input type="checkbox"/>	Prostate Cancer	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Gastro Reflux (GERD)	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>

Patient Signature: _____ Date: _____

Current Medications

Patient Name: _____ Birth date: _____

► List any current medications you are taking:

Anti Depressant:

- Effexor (venlafaxine)
- Cymbalta (duloxetine)
- Prozac (fluoxetine)
- Paxil (paroxetine)
- Wellbutrin (bupropion)
- Zoloft (sertraline)

Blood Thinners:

- Aspirin
- Coumadin (warfarin)
- Refludan (lepirudin)
- Ticlid (ticlopidine)
- Plavix (clopidogrel)
- Aggrastat (tirofiban)
- Integrilin (eptifibatide)

Cardiac/Hypertension:

- Capoten (captopril)
- Lisinopril
- Cozaar (losartan)
- Diovan (valsartan)
- Dyazide (hydrochlorothiazide)
- Nifedipine
- Verapamil
- Diltiazem
- Norvasc (amlodipine)
- Inderal (propranolol)
- Tenormin (atenolol)
- Lopressor (metoprolol)
- Coreg (carvedilol)
- Toprol

Anti Inflammatory

- Acetaminophen (Tylenol)
- Celebrex
- Naproxen (Aleve)
- Ibuprofen
- Prednisone

Other:

- _____
- _____

Anti Ulcer:

- Prilosec (omeprazole)
- Prevacid (lansoprazole)
- Nexium (esomeprazole)
- Protonix (pantoprazole)
- Tagamet (cimetidine)
- Zantac (ranitidine)

Cholesterol Lowering:

- Lipitor (atorvastatin)
- Zocor (simvastatin)
- Crestor (rosuvastatin)
- Mevacor (lovastatin)
- Niaspan (niacin)
- Gemfibrozil
- Zetia

Pain Medications:

- Darvocet
- Fentanyl
- Hydrocodone
- Lyrica
- MS Contin
- Neurontin
- Oxycodone
- OxyContin
- Percocet
- Tylenol #3
- Vicodin
- Vistaril
- Zanaflex

Osteoporosis Treatment:

- Actonel
- Fosamax
- Boniva

- _____
- _____

Allergy/Asthma:

- Allegra (fexofenadine)
- Claritin (loratadine)
- Singulair (montelukast)
- Zyrtec (cetirizine)
- Albuterol Inhaler
- Asthma-Steroid Inhaler (any brand)

Diabetes:

- Insulin Injections (any type)
- Glucophage (metformin)
- DiaBeta, Glynase or Micronase
- Glucotrol (glipizide)
- Glucagon
- Avandia (rosiglitazone)
- Precose (acarbose)

Antibiotics:

- Amoxicillin
- Augmentin (amoxicillin/potassium)
- Bactrim (trimethoprim)
- Biaxin (clarithromycin)
- Cipro
- Cleocin (clindamycin)
- Doxycycline
- Erythromycin
- Keflex (cephalexin)
- Levaquin (levofloxacin)
- Lamisil (terbinafine hydrochloride)
- Sporanox (itraconazole)
- Zithromax (azithromycin)

Reproductive:

- Birth Control Pills
- Depo-Provera Injections
- Hormone Replacement

- _____
- _____