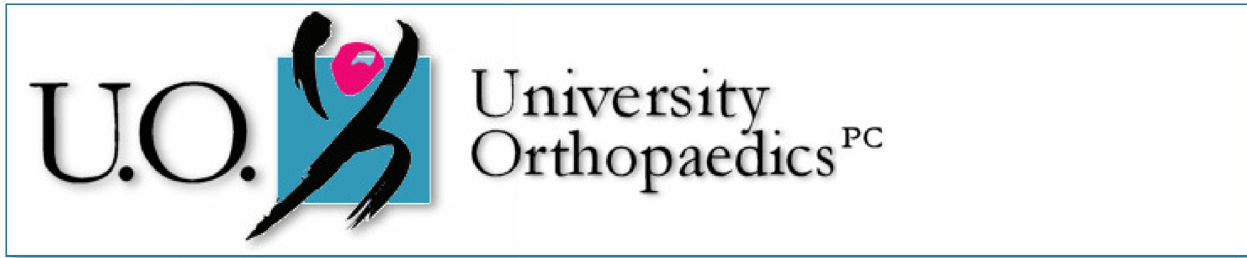

GENERAL
PATIENT INTAKE FORM

DIVISION OF SPORTS MEDICINE

Howard Luks, M.D., Chief
Daniel Zelazny, M.D., Attending

Name ____ Date _____________

1. Who referred you to us? Name __________________________Phone ____________

Address ____

2. Who is your Internist or Primary Care Physician? Name _________________________

Phone ___________ Address ____

3. Chief complaint or current illness? ____

Where do you experience this problem?

____

Are you: ☐ right-handed or ☐ left-handed

How long have you had this problem? ____

Is your problem getting ☐ worse ☐ better ☐ same

Was this the result of an injury? ☐ yes ☐ no

If yes, please describe: ____

If yes, is this a workers' compensation injury? ☐ yes ☐ no (if **yes**, please skip to **question 5**)

4. Work-related injury:

Job title: ________________________ How long with this employer? ____________

Date of injury: ____________ Are you: ☐ Off work ☐ Modified duty ☐ Full duty

If not full duty now, on which date did you last work full duty: ______________________

5. If pain is one of your complaints, please complete the following. If not, skip to question 6.

a. Rate the average intensity of your pain/discomfort. (0= no pain, 10= severe pain)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

b. Describe your pain:

☐ Intermittent ☐ Constant ☐ Dull ☐ Sharp ☐ Throbbing ☐ Tight ☐ Burning ☐ Tingling

6. Is your problem worse at any particular time of the day?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ All the time

7. Which activities increase your problem? (examples: stairs, walking, lifting, overhead)

____

8. Check yes or no for the following conditions; if yes, please describe.

	YES	NO	DESCRIBE
Stiffness			
Numbness			
Swelling			
Weakness			
Giving way			
Instability			
Other			

9. Have you tried any of the items below? If so, did they help?

	YES	NO	DESCRIBE	Helped	Didn't help
Medication			Type:		
Physical Therapy			For how long? Date of last visit:		
Injections			Where?		
Other:			Describe:		

10. Please list all medications you currently use with dosage and frequency:

____

____

11. Do you have any allergies? ☐ Yes ☐ No If yes, please list:

____

12. Have you ever had problems with any of the following? If yes, please describe.

	YES	NO	DESCRIBE:
Heart problem			
Breathing, lungs			
High blood pressure			
Cancer			
Diabetes			
Arthritis			
Hepatitis, AIDS, TB			
Liver problem			
Polio			
Epilepsy or seizures			
Bowel or colon			
Bladder problem			
Kidney problem			
Balance problem			
Numbness or tingling			
Blackout or fainting			

13. Please list all past surgeries and hospitalizations:

REASON	DATE	PHYSICIAN

14. Have you ever had problems with general anesthesia? ☐ YES ☐ NO

15. Do you drink alcohol? ☐ YES ☐ NO How much weekly? ___________________

16. Do you smoke? ☐ YES ☐ NO How much daily?______________ For how long? ________

17. Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed

18. Do you:

	YES	NO	
Have children?			How many?
Live alone?			If no, with whom?
Have a special diet?			Describe:
Use recreational drugs?			Describe:
Exercise regularly?			How often?

19. Sports or hobbies:

____

20. Family history:

	ALIVE	DECEASED	AGE	HEALTH	CAUSE OF DEATH
Father					
Mother					
Sibling					
Sibling					
Sibling					
Sibling					

21. Your height __________ Your weight __________

Thank you for your time in completing this information!

Reviewed by: ____________________________________, M.D. Date __________