First State Orthopaedics
www.FirstStateOrtho.com
4745 Ogletown-Stanton Road, Suite 225
Newark, DE 19713
302-731-2888 · Fax 302-731-7049

INTAKE FORM

□Dr.Axe □Dr.Bodenstab □Dr.Brady □Dr.Crain □Dr.Ginsberg □Dr.Handling □Dr.Hershey □Dr.Johnson □Dr.Kahlon □Dr.Katz
□Dr.Leitman □Dr.Moran □ Dr. Newell □Dr.Pushkarewicz □Dr.Raisis □Dr.Rudin □Dr.Sowa □Dr.Steele □Dr.Straight □Dr. Zaslavsky

PATIENT INFORMATION

Date: _____ **Name:** _____ **Age:** _____ **FSO MR #:** _____

REASON FOR VISIT - Ort Home

Body Part(s): _____ □ **Right** □ **Left** □ **Bilateral**

Complaint: □ Pain □ Injury □ Fracture □ Numbness □ Swelling □ Other: _____

HISTORY OF PRESENT INJURY - HPI: This Chief Complaint

(Please check all that apply)

Have you been off work for this problem?: □ Yes □ No **Dates off work**: _____

Doctors who have treated you for this problem: _____ **Did that doctor refer you here?**: □ Yes □ No

Diagnostic tests and treatment performed *(please list when/where/what)* : □ X-Ray _____ □ MRI _____

□ Injection _____ □ Surgery: _____ □ NSAIDS (anti-inflammatories) _____ □ EMG _____

□ CT/Scan _____ □ Bone Scan _____ □ Lab Work _____ □ Other: _____ □ PT _____

Have you ever had similar problems? If yes, please give details: _____

Onset/Date of Injury: _____ **Context**: □ No Injury □ Injury □ Sports Injury □ MVA - Details:_____

Severity:
□ Mild
□ Mild-Moderate
□ Moderate
□ Moderate-Severe
□ Severe

Status:
□ Changing
□ Improving
□ Fluctuating
□ Resolved
□ Stable
□ Worse

Frequency:
□ Intermittent
□ Occasional
□ Constant
□ Rare

Radiation: □ Yes □ No

Radiates To: _____

Quality:
□ Aching
□ Burning
□ Dull
□ Piercing
□ Sharp
□ Throbbing

Aggravated By:
□ Bending
□ Climbing Stairs
□ Decending Stairs
□ Lifting
□ Movement
□ Pushing
□ Sitting
□ Standing
□ Walking
□ Other: _____

Relieved By:
□ Brace/Splint
□ Elevation
□ Exercise
□ Heat
□ Ice
□ Injection
□ Massage
□ Pain/Rx Meds: _____
□ Mobility
□ OTC Meds: _____
□ PT
□ Rest
□ Stretching
□ Other: _____

Associated Symptoms / Pertinent Negatives:
□ Bruising
□ Crepitus (cracking sounds)
□ Decreased Mobility
□ Difficulty going to sleep
□ Instability
□ Limping
□ Locking
□ Night Pain
□ Night-time awakening
□ Numbness
□ Popping
□ Spasms
□ Swelling
□ Tingling in the arms
□ Tingling in the legs
□ Tenderness
□ Weakness
□ Other: _____

Hand Dominance:
□ Right □ Left
□ Ambidextrous

REVIEW OF SYSTEMS - Add Additional ROS

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:
□ Fatigue
□ Fever
□ Night Sweats

Cardiovascular:
□ Chest Pain
□ Cyanosis (blue coloration of skin)
□ Irregular Heartbeats/Palpatations

Integumetary/Skin:
□ Rash

Metabolic/Endocrine:
□ Cold Intolerant
□ Heat Intolerant

HEENT:
□ Headache
□ Vision Loss

Gastrointestinal:
□ Constipation
□ Diarrhea
□ Nausea
□ Vomiting

Neurological:
□ Difficulty Walking
□ Dizziness

Hematologic/Blood:
□ Bleeding

Respitory:
□ Cough
□ Dyspnea

Genitourinary:
□ Dysuria
□ Hematuria

Immunological:
□ Enviromental Allergies
□ Food Allergies

□ **None**

PATIENT'S MEDICAL CONDITION - Assistant Doc>Vital Signs

Height: ___ft ___in **Weight:** _____lbs **Blood Pressure:**_____/_____ **List details of any diet program:** _____

My weight in the last 6 months has: □ **Not Changed** □ **Increased** _____**lbs.** □ **Decreased** _____**lbs.**

Have you ever taken any anti-inflammatories/arthritis medications?: □Yes □No (**Ex**: Naprosyn/Ibuprofen) If yes, please list: _____

ALLERGIES - Assistant Doc>Add Allergy

(Please check all in which you have an allergy and list the reaction - hives, nausea, anaphylaxis, etc)

	Reaction:		**Reaction:**		**Allergy & Reaction:**
□ Aspirin	_____	□ NSAIDs (anti-inflammatories - ibuprofen, naprosyn)	_____	□ Other:	_____
□ Codeine	_____	□ Narcotics (Percocet, Vicodin)	_____	□ Other:	_____
□ IV Dye	_____	□ Penicillin	_____	□ Other:	_____
□ Latex	_____	□ Sulfa	_____	□ **No Known Drug Allergies**	

PATIENT'S MEDICAL HISTORY - Histories>Additional History

(Please check all that apply)

□ AIDS/HIV	□ COPD (Emphysema)	□ High Blood Pressure	□ Parkinson Disease	□ **None**
□ Alcoholism	□ Coronary Artery Disease	□ Hyperthyroidism	□ Peptic Ulcer Disease	
□ Alzheimers	□ Crohn's Disease	□ Hypothyroidism	□ Psoriasis	□ Other:
□ Anemia	□ Degenerative Joint Disease	□ Inflammatory Bowel Disease	□ PVD	
□ Angina	□ Depression	□ Juvenile Rheumatoid Arthritis	□ Renal Disease	_____
□ Arthritis	□ Diabetes	□ Kidney Disease	□ Rheumatoid Arthritis	
□ Asthma	□ Drug Abuse	□ Liver Disease	□ Scoliosis	_____
□ Atrial Fibrillation	□ DVT (Blood Clot)	□ Lyme Disease	□ Seizure Disorder	
□ Benign Prostatic Hyertrophy	□ Fibromyalgia	□ Migraine Headaches	□ Sleep Apnea	_____
□ Cancer	□ Gallbladder Disease	□ Multiple Sclerosis	□ SLE (Lupus)	
□ Cerebrovascular Accident (Stroke)	□ GERD	□ Myocardial Infarction	□ Spinal Stenosis	_____
	□ Gout	□ Obesity	□ Thyroid Disease	
□ Congestive Heart Failure (CHF)	□ Hepatitis	□ Osteoarthritis	□ Valvular Disease (Heart valve problems)	_____
	□ High Cholesterol	□ Osteoporosis		

PATIENT'S SURGICAL HISTORY - Histories>Additional History

(Please check all that apply)

□ ACL Surgery	□ CABG	□ Hip Replacement	□ Pacemaker	□ Other:
□ Angioplasty	□ Cardiac (Heart) Valve Replacement	□ Knee Replacement	□ Small Bowel Resection	_____
□ Angio w/stent		□ Laminectomy	□ Thyroidectomy	
□ Appendectomy	□ Carpal Tunnel Release	□ LASIK	□ Tonsillectomy	_____
□ Athroscopy (Scope) Details:	□ Cataract Extraction	□ Meniscus Surgery	**Gender Specific**	
	□ Cholecystectomy	□ Muscle Biopsy	**Female**	_____
_____	(gallbladder removal)	□ Neck Surgery - Details:	□ Cesarean Section	
□ Back Surgery - Details:	□ Colectomy		□ Hysterectomy	_____
	□ Colostomy	_____	□ Mastectomy	
_____	□ Discectomy		**Male**	_____
	□ Gastric Bypass	_____	□ Prostatectomy	
_____	□ Hernia Repair	□ ORIF	□ TURP	□ **None**

PATIENT'S FAMILY HISTORY - Histories> Additional Family History

Is your Father Living? □ Yes □ No If no, age deceased _____ cause of death _____

Is your Mother Living? □ Yes □ No If no, age deceased _____ cause of death _____

Are any of your brothers/sisters deceased? □ Yes □ No If yes, age deceased _____ cause of death _____

Family history of chronic/inherited diseases: _____

PATIENT'S SOCIAL HISTORY - Histories>Social History

Tobacco Use: □ Yes □ No □ Former/Year Quit _____ **Consume Alcohol**: □ Yes □ No □ Former/Year Quit _____

Activity Level: □ Sedentary □ Moderate □ Vigorous **Type of Exercise**: _____ _____

SIGNATURE

Date: _____ **Signature of Patient, Parent or Guardian:** _____