Webster Orthopedics
Experience. Excellence.

New Patient Intake

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PATIENT NAME: _____

Sex: ☐ M ☐ F

Date of Birth: _____/_____/_____ Age: _____

WORKER'S COMPENSATION PATIENTS ONLY:

Is this issue covered by workers' comp? ☐ YES ☐ NO

Are you coming in for a new work-related injury? ☐ YES ☐ NO

Who is your primary treating physician? _____

Is your insurance or employer specifically requesting this exam for employment or medical disability purposes? ☐ YES ☐ NO

Are all of the symptoms you want to discuss today from the work-related injury? ☐ YES ☐ NO

NEW PATIENTS ONLY:

Referring Provider: _____

Were you referred by a doctor at this clinic or in this medical group? ☐ YES ☐ NO

When did your symptoms originally begin (estimated date)? _____

Was there a specific injury? ☐ NONE ☐ SPORTS ☐ FALL ☐ CAR ACCIDENT ☐ OVERUSE ☐ OTHER

Please describe how symptoms started: _____

_____

How would you describe your symptom progress? ☐ IMPROVING ☐ UNCHANGED ☐ WORSENING

How did you hear about us? ☐ FRIEND/FAMILY ☐ YELP ☐ GOOGLE ☐ OTHER: _____

ALL PATIENTS:

1) Which body part is **most affected**?

Which side? ☐ RIGHT ☐ LEFT ☐ BOTH Specifically? ☐ FRONT ☐ BACK ☐ INSIDE ☐ OUTSIDE

Which area? ☐ KNEE ☐ HIP ☐ THIGH ☐ CALF ☐ ANKLE ☐ FOOT ☐ TOE(S): _____ ☐ BACK

☐ SHOULDER ☐ ARM ☐ HAND ☐ WRIST ☐ FINGER(S): _____ ☐ OTHER: _____

2) Have you had a recent **re-injury** to this area? ☐ YES ☐ NO

If yes, how: ☐ SPORTS INJURY ☐ FALL ☐ CAR ACCIDENT ☐ OVERUSE ☐ WORK ☐ OTHER

If yes, when? _____ Please describe: _____

3) How likely do you think your symptoms will **require surgery**?

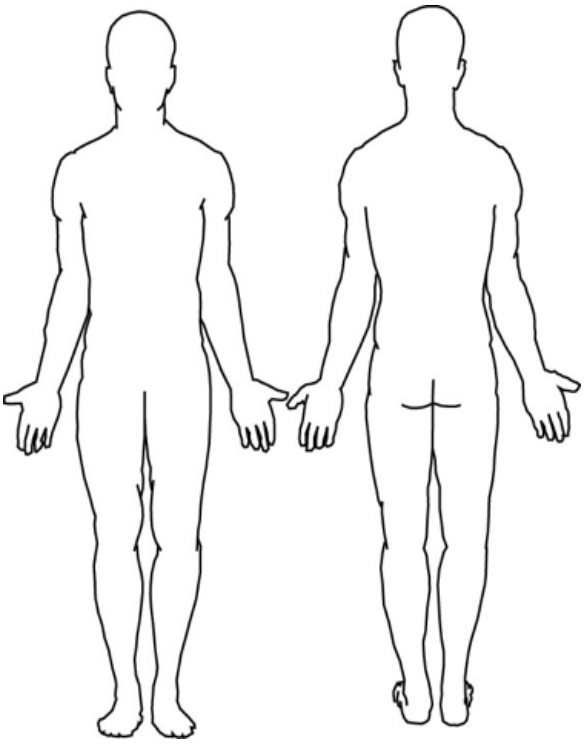
☐ I JUST HAD SURGERY ☐ VERY UNLIKELY ☐ UNLIKELY ☐ UNSURE ☐ LIKELY ☐ VERY LIKELY

4) What **diagnoses** have your recieved for these symptoms, if any? _____

_____

SYMPTOMS

Draw the appropriate symbols in the areas you want to discuss on the diagram below:



XXXXX for **PAIN** ☐ NONE

If you have **pain**, how would you describe its:

Timing ☐ CONSTANT ☐ INTERMITTENT ☐ WITH ACTIVITY
Quality ☐ ACHING ☐ STABBING ☐ DULL
Severity ☐ MILD ☐ MODERATE ☐ SEVERE
Scale (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST)

△△△△△ for **NUMBNESS/TINGLING** ☐ NONE

If you have **numbness or tingling**, describe its:

Timing ☐ CONSTANT ☐ INTERMITTENT ☐ WITH ACTIVITY
Severity ☐ MILD ☐ MODERATE ☐ SEVERE

○○○○○ for **SWELLING** ☐ NONE

If you have **swelling**, how would you describe its:

Timing ☐ CONSTANT ☐ INTERMITTENT ☐ WITH ACTIVITY
Severity ☐ MILD ☐ MODERATE ☐ SEVERE

5) Are you experiencing any of these additional **symptoms**?

☐ LIMITED MOTION ☐ WEAKNESS ☐ POPPING/LOCKING ☐ INSTABILITY ☐ _____

6) How are your symptoms affecting your ability to **work**?

☐ NO EFFECT ☐ LIMITED DUTY ☐ UNABLE TO WORK DETAILS: _____

7) What makes your symptoms **worse**?

☐ STANDING ☐ WALKING ☐ LIFTING ☐ SITTING ☐ STAIRS ☐ GRASPING ☐ _____

8) Are you experiencing any **difficulty with activities** you like to do?

☐ SLEEPING ☐ EXERCISING ☐ PLAYING SPORTS ☐ More: _____

TREATMENTS	Did it provide relief?	Are you still using this?
☐ Rest ☐ Ice ☐ Heat ☐ Brace ☐ Elevation	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED
☐ Avoiding activities: _____	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED
☐ Oral anti-inflammatories: ☐ CELEBREX ☐ IBUPROFEN ☐ ASPIRIN ☐ NAPROXEN	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED
☐ Topical anti-inflammatories: _____	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED
☐ Physical therapy sessions: #_____	☐ NONE ☐ SOME ☐ A LOT	LAST DATE: ___/___/_____
☐ Cortisone injections: #_____	☐ NONE ☐ SOME ☐ A LOT	LAST DATE: ___/___/_____
☐ Viscosupplementation injections: #_____	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED
☐ Positional changes (i.e. lifting arm over head)	☐ NONE ☐ SOME ☐ A LOT	☐ ONGOING ☐ DISCONTINUED

Other: _____

SOCIAL HISTORY

Occupation: _____ ☐ RETIRED ☐ UNEMPLOYED

Exercise Type: ☐ WEIGHTLIFTING ☐ AEROBICS ☐ STRETCHING ☐ OTHER Times/Week: _____

Tobacco Use: ☐ CURRENT ☐ PREVIOUS ☐ NONE Number of Years: _____ Packs/Day: _____

Alcohol Use: ☐ YES ☐ NO Amount: _____ Recreational Drug Use: ☐ YES ☐ NO Description: _____

PERSONAL AND FAMILY MEDICAL HISTORY

Have **YOU or family members been diagnosed** with any of the following:

	Self	Father	Mother	Brother	Sister
ARTHRITIS	☐	☐	☐	☐	☐
GOUT	☐	☐	☐	☐	☐
RHEUMATOLOGIC (I.E. LUPUS)	☐	☐	☐	☐	☐
CARPAL TUNNEL SYNDROME	☐	☐	☐	☐	☐
OSTEOPOROSIS	☐	☐	☐	☐	☐
THYROID DISEASE	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐
HYPERTENSION	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐
RENAL / KIDNEY DISEASE	☐	☐	☐	☐	☐
OTHER(S): _____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐

SURGICAL HISTORY

Have you had any **previous surgeries**?

☐ JOINT REPLACEMENT ☐ ACL RECONSTRUCTION ☐ MENISCAL REPAIR ☐ CARPAL TUNNEL RELEASE ☐ LABRAL REPAIR ☐ SURGICAL FRACTURE REPAIR ☐ ROTATOR CUFF REPAIR ☐ JOINT/SPINE FUSION ☐ CARDIAC BYPASS ☐ CARDIAC STENTING ☐ PACEMAKER PLACEMENT ☐ OTHER

Surgery: _____ Surgeon: _____ Year: _____

Surgery: _____ Surgeon: _____ Year: _____

Surgery: _____ Surgeon: _____ Year: _____

SPECIFIC MEDICATIONS

Are you taking any of the following **medications**?

☐ ANTI-INFLAMMATORIES ☐ BLOOD THINNERS (E.G. WARFARIN, XERALTO, LOVENOX, PLAVIX) ☐ BETA-BLOCKERS (E.G. ATENOLOL, METOPROLOL) ☐ OPIOIDS (E.G. FENTANYL, OXYCONTIN)

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

ALLERGIES & ADVERSE REACTIONS

☐ PENICILLIN ☐ SULFA DRUGS ☐ ANTIBIOTICS ☐ PAIN MEDS ☐ LATEX ☐ ANESTHESIA

Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____

REVIEW OF SYSTEMS

Please **mark** any symptoms you are experiencing:

General: ☐ WEIGHTLOSS ☐ FATIGUE ☐ APPETITE CHANGES ☐ NIGHT SWEATS ☐ FEVER/CHILLS

Eyes, Ears, Nose & Throat:

☐ VISION / HEARING CHANGES
☐ RINGING IN EARS
☐ SORE THROAT
☐ SINUS PAIN
☐ HOARSENESS

Urologic:

☐ BLOOD IN URINE
☐ BURNING WHEN URINATING
☐ FREQUENT URINATION
☐ IMPOTENCE
☐ PAINFUL INTERCOURSE

Heme/Lymphatic:

☐ EASY BRUISING
☐ BLOOD CLOTTING
☐ SWOLLEN LYMPH NODES
☐ FREQUENT NOSE BLEEDS
☐ ABNORMAL BLOOD TEST

Cardiovascular:

☐ CHEST PAIN
☐ IRREGULAR HEART BEAT
☐ SWELLING IN LEGS OR FEET
☐ POOR CIRCULATION
☐ EXERCISE INTOLERANCE

Skin:

☐ HAIR LOSS
☐ ITCHING
☐ RASHES
☐ EXCESSIVE DRYNESS
☐ GROWTHS OR LESIONS

Allergic/Immunologic:

☐ SEASONAL ALLERGIES
☐ HIVES
☐ FREQUENT INFECTIONS
☐ POSITIVE TB OR HEPATITIS
☐ HIV POSITIVE

Respiratory:

☐ SHORTNESS OF BREATH
☐ WHEEZING
☐ COUGHING
☐ COUGHING UP BLOOD
☐ SPUTUM PRODUCTION

Musculoskeletal:

☐ JOINT PAIN
☐ SWOLLEN JOINTS
☐ JOINT INSTABILITY
☐ MUSCLE WEAKNESS
☐ STIFFNESS OR CRAMPING

Psychiatric:

☐ DEPRESSION
☐ ANXIETY
☐ INSOMNIA
☐ HALLUCINATIONS
☐ MOOD SWINGS

Gastrointestinal:

☐ FREQUENT HEARTBURN
☐ DIFFICULTY SWALLOWING
☐ ABDOMINAL PAIN
☐ NAUSEA OR VOMITING
☐ DIARRHEA OR CONSTIPATION

Endocrine:

☐ HEAT OR COLD SENSITIVITY
☐ INCREASED THIRST
☐ EXCESSIVE SWEATING
☐ CHANGES IN SEX DRIVE
☐ MENSTRUAL IRREGULARITIES

Neurologic:

☐ FREQUENT HEADACHES
☐ TREMORS
☐ DIZZINESS OR VERTIGO
☐ LOSS OF BALANCE
☐ SEIZURES

ABOUT YOURSELF

Is there **anything else** you'd like your provider to know about you? _____

_____

_____

_____