**ORTHOPEDIC & SPORTS CARE, CORAL**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_ AGE \_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Health Providers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How and when did the injury occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the symptoms which prompted you to see us: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **REVIEW of SYSTEMS** - Please mark an “X” if you have had any of the following

**CARDIOVASCULAR**

* High blood pressure
* Chest discomfort
* Angina
* Heart attack
* Shortness of breath
* Diﬃculty breathing when lying down
* Wake up at night short of breath
* Congestive heart failure
* Elevated cholesterol, Triglycerides, lipids
* Passing out
* Palpitations or fl utters
* Swelling of the ankles
* Heart valve disease
* Murmur
* Leg pain while walking
* Phlebitis
* Varicose veins
* Blood clots

**RESPIRATORY**

 ●Emphysema

 ●Asthma

**NEUROLOGICAL**

* Headache or migraines
* Head injury
* Concussion
* Loss of consciousness
* Stroke
* Seizures
* Numbness, weakness, or loss of feeling in arm/leg
* Temporary diﬃculty speaking
* Temporary loss of vision
* TIAs

**GASTROINTESTINAL**

* Indigestion
* Gastroesophageal Refl ux (GERD)
* H. pylori
* Hiatal hernia
* Ulcers
* Irritable Bowel Syndrome

**ENDOCRINE**

* Thyroid problem
* Diabetes

**CONSTITUTIONAL**

* Weight Gain/loss
* Fatigue

**HEMATOLOGY**

* Bleeding problems
* Anemia

**GENITOURINARY**

* Sexual dysfunction
* Prostate
* Kidney
* OB/GYN
* Children
* LMP
* Menopause

**PSYCHIATRIC**

● Anxiety

● Depression

● Other

**MUSCULOSKELETAL**

● Joint pain

● Arthritis

Other Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flu shot this year?  Yes  No Pneumonia vaccination in the past? ● Yes ● No What year?

**PAST MEDICAL HISTORY**

Name any serious illnesses you have including childhood illnesses and hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Operations and Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The above information is true and correct to the best of my belief.*

MD signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intake form reviewed and confirmed with patient ●Yes ●No