Riverside Orthopaedic and Sports Medicine

Intake Questionnaire

Name _____ ◯ **Male** ◯ **Female**

Pharmacy _____ **Date of Birth** _____ **Age** _____

(Duane Reade at 57th and Broadway will be used as default)

Pharmacy Address _____

_____ **Height** _____ ' _____ " **Weight** _____ lbs.

_____

Pharmacy Phone _____ **Hand Dominance** ◯ **RIGHT** ◯ **LEFT**

Date of Injury _____

Length of Problem _____ days _____ weeks _____ months _____ years

Current Pain Level 0 1 2 3 4 5 6 7 8 9 10 (Please circle pain level)

Chief Complaint: Below please describe the current injury / complaint and symptoms

_____

_____

_____

Present Medications Please list all medications (prescription/over the counter/supplements) and dosage that you are currently taking or have taken within the last month

_____ _____

_____ _____

_____ _____

_____ _____

Medication Allergies ◯ None

◯ Penicillin ◯ Ibuprofen ◯ Tetracycline ◯ Metals ◯ Shellfish

◯ Sulfa ◯ Codeine ◯ Local Anesthetic ◯ Latex ◯ Other

◯ Aspirin ◯ Erthyromycin ◯ Fluoride ◯ Iodine _____

Food Allergies ◯ None ◯ Yes: _____

Riverside Orthopaedic and Sports Medicine

Surgical History

◯ None ◯ Yes

Please list all prior surgeries and dates

_____

_____

Social History

◯ Working ◯ Unemployed ◯ Retired ◯ Student

Occupation : _____

Marital ◯ Married ◯ Single

Smoker ◯ No ◯ Yes _____ packs per day x _____ years

Alcohol ◯ No ◯ Yes (◯ Occassional ◯ Moderate ◯ Heavy)

Family History

Father : ◯ Living Age _____ ◯ Deceased

Problems ◯ *Arthritis* ◯ *Cancer* ◯ *Diabetes* ◯ *Stroke* ◯ *Heart Disease* ◯ *Other:* _____

Mother : ◯ Living Age _____ ◯ Deceased

Problems ◯ *Arthritis* ◯ *Cancer* ◯ *Diabetes* ◯ *Stroke* ◯ *Heart Disease* ◯ *Other:* _____

Past Medical History ----------> Please check all medical conditions that apply

◯ None	◯ GERD / Reflux	◯ Numbness / Tingling	◯ Breast Cancer
◯ Migraines	◯ Crohn's / IBS	◯ Osteoarthritis	◯ Thyroid Cancer
◯ Difficulty Hearing	◯ Hemorrhoids	◯ Rheumatoid Arthritis	◯ Prostate Cancer
◯ Hypertension	◯ Hepatitis	◯ Fibromyalgia	◯ Colon Cancer
◯ Coronary Heart Disease	◯ Urinary Tract Infection	◯ RSD	◯ Leukemia
◯ Varicose Veins	◯ Kidney Stones	◯ Psoriasis	◯ Lung Cancer
◯ Stroke	◯ Uterine Fibroids	◯ Eczema	◯ HIV
◯ Pneumonia	◯ End Stage Renal Dz	◯ Skin Disorder	◯ Tuberculosis
◯ COPD	◯ Seizures	◯ Thyroid	◯ Epstein - Barr
◯ Asthma	◯ Parkinson's	◯ Diabetes	◯ Lyme
◯ Emphysema	◯ Alzheimer's	◯ Gout	◯ Lupus
◯ Congestive Heart	◯ Dementia	◯ Coagulopathy	◯ Other _____
◯ Peptic Ulcer Disease	◯ Multiple Sclerosis	◯ Clotting Disorder	

Riverside Orthopaedic and Sports Medicine

Review of Symptoms ----------> Please check all symptoms that apply

Constitutional

- ◯ Fever
- ◯ Exercise Intolerance
- ◯ Weight gain _____ lbs.
- ◯ Weight loss _____ lbs.
- ◯ Night Sweats

Eyes

- ◯ Dry Eyes
- ◯ Irritation
- ◯ Vision Change

Ears, Nose, Mouth, Throat

- ◯ Difficulty Hearing
- ◯ Sinus Problems
- ◯ Snoring
- ◯ Mouth Ulcer
- ◯ Ear Pain
- ◯ Sore Throat
- ◯ Dry Mouth
- ◯ Teeth Abnormalities
- ◯ Frequent Nosebleeds
- ◯ Bleeding Gums
- ◯ Oral Abnormaities

Repiratory

- ◯ Cough
- ◯ Wheezing
- ◯ Shortness of Breath
- ◯ Coughing Up Blood

Cardiovascular

- ◯ Chest Pain on Exertion
- ◯ Palpitations
- ◯ Shortness of Breath
- ◯ Known Heart Murmurs
- ◯ Arm Pain on Exertion

Gastrointestinal

- ◯ Abdominal Pain
- ◯ Vomiting
- ◯ Change in Appetite
- ◯ Diarrhea
- ◯ Black Stools
- ◯ Bowel Incontinence
- ◯ Constipation

Genitourinary

- ◯ Urinary Loss
- ◯ Difficulty Urinating
- ◯ Urinary Frequency
- ◯ Hematuria
- ◯ Incomplete Emptying

Musculoskeletal

- ◯ Muscle Aches
- ◯ Muscle Weakness
- ◯ Arthralgias/Joint Pain
- ◯ Back Pain

Skin

- ◯ Abnormal Mole
- ◯ Jaundice
- ◯ Eczema
- ◯ Rash

Psychiatric

- ◯ Depression
- ◯ Mania
- ◯ Sleep Disturbances
- ◯ Alcohol Abuse
- ◯ Feel Unsafe in Relationship

Neurologic

- ◯ Loss of Consciousness
- ◯ Numbness
- ◯ Weakness
- ◯ Dizziness
- ◯ Seizures
- ◯ Headaches

Endocrine

- ◯ Fatigue
- ◯ Increased Thirst
- ◯ Hair Falling Out
- ◯ Increased Hair Growth

Hematologic / Lymphatic

- ◯ Swollen Glands
- ◯ Bruising
- ◯ Bleeding Problems

Allergic / Immunologic

- ◯ Runny Nose
- ◯ Hives
- ◯ Sinus Pressure
- ◯ Itching
- ◯ Frequent Sneezing