North Shore LIJ | NORTH SHORE-LIJ Orthopaedic Institute
1000 Northern Blvd
Suite 110
Great Neck, NY 11021
516-325-7240

Physician for Today's Appt: _____ Date: ___/___/_____

Patient Intake and History Form

Please provide the following information. This form is confidential and will be entered into your medical record.

Name: _____ **Date of Birth:** ____/____/_____
Last First MI

Past Medical History *(Please check any condition you have now or have had in the past)*

☐*No Past Medical History*	☐Seizures/Epilepsy	☐Rheumatoid Arthritis
☐Asthma	☐Parkinson's Disease	☐Cancer:(type_____)
☐COPD	☐Stroke	☐Prolonged Steroid Treatment
☐Diabetes	☐Arthritis (location_____)	☐Other:
☐Heart Disease	☐Herniated Disc	_____
☐High Cholesterol	☐Osteoporosis	_____
☐Hypertension	☐Spinal Stenosis	_____
☐Neuropathy	☐Lupus	_____

Females Only: Do you think you might be pregnant at this time? ☐Yes ☐No
Last Menstrual Period: ____/____/_____ ☐ Not Applicable

Surgery and Hospitalization History
☐*No Past Surgery/Hospitalizations*

Reason for Surgery/Hospitalization	Hospital Name (if available)	Date (approximate)

Family History *Have any family members had the following?*

Cancer: ☐Yes ☐No If yes, who? _____ Type: _____
_____ Type: _____
Osteoporosis: ☐Yes ☐No If yes, who? _____ Type: _____
Arthritis/Deg Joint Disease: ☐Yes ☐No If yes, who? _____ Loc: _____
Genetic Disease: ☐Yes ☐No If yes, who? _____ Type: _____

Social History

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Living Situation: ☐Alone ☐With Family
Occupation: _____ presently working? ☐Yes ☐No ☐House ☐☐Apartment
☐ Stairs

Do you smoke cigarettes? ☐Yes ☐No ☐Former Smoker
If Yes, how many packs per day? ☐<1 ☐1-2 ☐3+ how long? ☐< 1 year ☐1-10 years ☐10+years
Do you drink alcohol? ☐Occasionally ☐Regularly ☐Never
Do you use recreational drugs? ☐Occasionally ☐Regularly ☐Never
If Yes to the above two questions, have you ever been treated for dependency in the past? ☐Yes ☐No

Social History cont.

Do you exercise? ☐Occasionally ☐Regularly ☐Never Intensity: ☐high ☐low

List activities: _____

Do you have a health care proxy? ☐Yes ☐No

Allergies (*Please check all that apply)*

☐ *No Known Allergies*

☐Shellfish
☐Contrast Dye
☐Latex
☐Seasonal
☐General/Local Anesthetic
☐Medication: _____
☐Other: _____

Current Medications (*Please list all medications including vitamins and supplements)*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

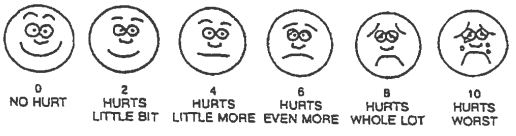
Have you recently taken or used?

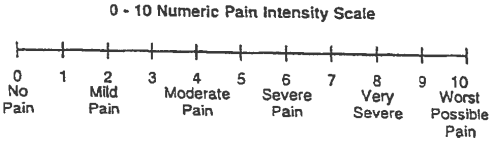
☐NSAIDS: (Aleve, Ibupr. Aspirin) ☐Tylenol ☐Ice/Compression ☐ Other OTC: _____

Reason for your visit today: _____

Current Height: ____ ft ____ in Current Weight: ____lbs

Severity of Pain (0-10 Scale): *Please mark an "X" where your pain is at this time* Location: _____





Review of Systems *(Please check any of the following symptoms you have experienced recently)*

☐Chills	☐Feeling Tired	☐Fever	☐Recent Weight Gain
☐Discharge	☐Eye Pain	☐Sight Problems	☐Redness
☐Decreased Hearing	☐Nasal Discharge	☐Nosebleeds	☐Sore Throat
☐Short of Breath at rest	☐Cough	☐ Short of Breath w/exertion	☐ Leg Swelling
☐Abdominal Pain	☐Constipation	☐Diarrhea	☐Heartburn
☐Urinary Freq	☐Urinary Urgency	☐Incontinence	☐Abnormal Vaginal Bleeding
☐Arthralgias	☐Joint Pain	☐Joint Stiffness	☐Joint Swelling
☐Breast Pain	☐Breast Lump	☐Skin Lesions	☐Change in a mole
☐Headache	☐Dizziness	☐Fainting	☐Convulsions
☐Anxiety	☐Depression	☐Sleep Disturbances	
☐Deepening Voice	☐Feeling Weak	☐Hot Flashes	☐Muscle Weakness
☐Easy Bleeding	☐Easy Bruising	☐Swollen Glands	

Signature of Patient: _____ **Date:** _____

Patient Representative Name **Signature** **Relationship** **Date**