



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)
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Family History Have any family members had the following?

Cancer: ☐ Yes ☐ No If yes, who? _____ 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. _____

5. _____

2. _____

6. _____

3. _____

7. _____

4. _____

8. _____

Have you recently taken or used?

☐ NSAIDs: (Aleve, Ibuprofen, Aspirin) ☐ Tylenol ☐ Ice/Compression ☐ Other OTC: _____

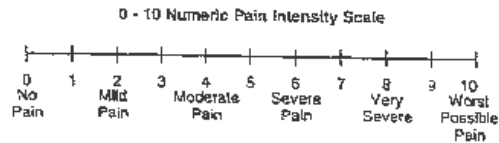
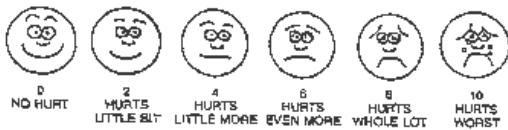
Reason for your visit today: _____

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

☐ Muscle Weakness

☐ Deepening Voice

☐ Feeling Weak

☐ Hot Flashes

☐ Easy Bleeding

☐ Easy Bruising

☐ Swollen Glands

Signature of Patient: _____ Date: _____

Patient Representative Name

Signature

Relationship

Date