Holy Cross Medical Group Orthopedic Institute Patient Intake

General Medical History – Page 1 of 2 Martin W. Roche, M.D.

Affected Side of the Body: Right SideLeft SideBoth Sides Area of the Body Affected: KneeShoulderHipAnkleFootElbowHand Spine How long have you had this problem?	Date:	- 2					
fereired, what was your date of retirement:	Last Name:			First:		N	/liddle Initial:
fretired, what was your date of retirement: Email Address: dome Phone:	Date of Birth:	Age:	Height:ft.	in. Weig	jht:	_lbs. Right/Lef	t Handed:
Home Phone: Work Phone:	Employer:			Occup	oation:		
Family Physician:	If retired, what was your dat	te of retirement: _		Email Add	lress:		- 4
Referred By: Local Pharmacy:	Home Phone:	\	Nork Phone:		Ce	ell Phone:	
Affected Side of the Body: Right Side _ Left Side _ Both Sides _ Area of the Body Affected: Knee _ Shoulder _ Hip _ Ankle _ Foot _ Elbow _ Hand Spine _ How long have you had this problem? _ sthis the result of an injury? No _ Yes _ If yes, please describe how the injury occurred: _ sthis a Workman's Compensation injury? No _ Yes _ Does it involve medical-legal claims? No _ Yes _ Previous Treatments (IN REGARD TO YOUR KNEE PAIN) Medications: Do you ever use any of these medications to treat your knee pain? No _ Yes _ Advil _ Aleve _ Tylenol _ Motrin _ Celebrex _ Mobic _ Ibuprofen _ Tramadol _ Any other medications used to treat your knee pain? _ Date(s):	Family Physician:					_ Phone:	
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Area of the Body Affected: KneeShoulderHipAnkleFootElbowHand Spine flow long have you had this problem?	Presenting Complaint						
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Symptoms: Swelling				\$2000000 Et 07	5.8 US		ant
0-10 Numeric Pain Rating Scale							
0-10 Numeric Pain Rating Scale							
0 1 2 3 4 5 6 7 8 9 10	,				Scale		
		1 2	+	 	+ +		10
No Pain Moderate Pain Worst Possible Pain	No Pain	. 2			, 0		

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Past Medical History: Have you	u had or have any of the follo	owing? (check all that apply) NO	NE	
High Blood Prressure	Hepatitis	Asthma	Multiple Sclerosis	
Mitral Valve Prolapse	Ulcers	Rash/Skin Lesion	Parkinsons	
Diabetes	Heart Attack/MI	Recent Cold	Emphysema/Lung Disease	
Kidney Disease	Blood Clots/DVT	Gout	_ Bronchitis	
Cancer	Seizures	Angina	HIV/AIDS	
Back/Disk Disease	Sickle Cell Anemia	Bleeding Disorder	TB	
Osteoporosis	Atrial Fibrillation	Thyroid Disease	Past Blood Transfusions	
Rheumatoid Arthritis	Psoriatic Arthritis	RSD	Fibromyalgia	
Review of Symptoms: Have yo	u had any of the following?	(check all that apply) NONE	_	
Fever/Night Sweats	Difficulty Breathing	Unexplained Weight Losss	Sore Throat/Ear Ache	
Stomach Pain	Chest Pain	Bladder Problems/Infections	Depression	
Numbness	Cramps	Bleeding Tendency	Hot Flashes	
Other (Explain):				
Do you have any metal allergie	es or sensitivities?			
List of Allergies:				
l ist of medications currently h	eing taken and provide dos	age and number of times taken p	er dav:	
List of medications carrently is	reing taken and provide door	age and namber of times taken p		
List any surgen or beeniteline	tion that you have had			
List any surgery or hospitaliza		Dat	01	
			e:	
			e:	
			e:	
		Dat	e:	
01-118-1				
Social History:		0 11 11 11 11	Demonstic Destroy	
		Saparated Widowed _		
Family History: Children: Yes	No IF YES, ho	w many? Male Female		
	•			
Do you use any of the followin		0 10 1	K L	
		r Current Smoker	Secretaria de la companya de la comp	
		ch per day?		
Controlled Narcotics Yes		how often?		
Other Drugs Yes	No What and	how often?		
Family Medical History: (chec	k all that apply) NONE	_		
(75) (5) (5) (7)		blems with Anesthesia Dia	abetes Obesity	
Other:			Second # Min	
			Datas	
Patient Signature:			Date:	
OFFICE USE ONLY				
Reviewed By:		Date:	Time:	
Davious d Pvr		Data:		