Holy Cross Medical Group
Orthopedic Institute Patient Intake

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

Date: _____

Last Name: _____ First: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Height: _____ft. _____in. Weight: _____lbs. Right/Left Handed: _____

Employer: _____ Occupation: _____

If retired, what was your date of retirement: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Family Physician: _____ Phone: _____

Referred By: _____ Local Pharmacy: _____ Pharmacy Number: _____

Presenting Complaint

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? _____

Is this the result of an injury? No ___ Yes ___ If yes, please describe how the injury occurred: _____

Is this 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? _____

Injections: Have you had cortisone injection(s) into your knee before? _____ Date(s): _____

Have you had lubricating injection(s) into your knee before? _____ Date(s): _____

Bracing: _____ **Do you ever need an assistive walking device?** No ___ Yes ___

If yes, what device(s)? Wheel Chair, Cane, Walker, Crutches

Have you done Physical Therapy or an Exercise Program for your knees? No ___ Yes ___ Date(s): _____

What activities does your knee prevent your from doing or make difficult to do? _____

Does your knee pain prevent you from performing the activities of daily living? _____

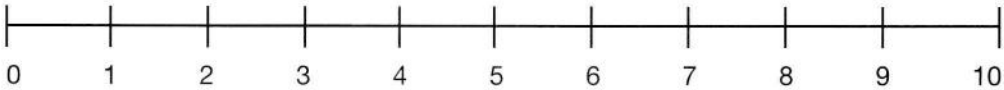
Is your knee pain changing in quality? Worse ___ Better ___ Staying the same ___

Please describe your pain: Quality: Dull ___ Throbbing ___ Sharp ___ Intermittent ___ Constant ___

Symptoms: Swelling ___ Bruising ___ Redness ___ Heat ___ Numbness ___ Weakness ___ Giving Way ___

Other Symptoms: _____

0-10 Numeric Pain Rating Scale



No Pain Moderate Pain Worst Possible Pain

Past Medical History: Have you had or have any of the following? (check all that apply) NONE _____

_____ 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 you 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 allergies or sensitivities? _____

List of Allergies: _____

List of medications currently being taken and provide dosage and number of times taken per day: _____

_____

_____

_____

List any surgery or hospitalization that you have had:

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Social History:

Marital Status: Single _____ Married _____ Divorced _____ Saparated _____ Widowed _____ Domestic Partner _____

Family History: Children: Yes _____ No _____ IF YES, how many? Male _____ Female _____

Do you use any of the following?

Tobacco Never a Smoker _____ Past Smoker _____ Current Smoker _____ If so, how much daily? _____

Alcohol Yes _____ No _____ How much per day? _____

Controlled Narcotics Yes _____ No _____ What and how often? _____

Other Drugs Yes _____ No _____ What and how often? _____

Family Medical History: (check all that apply) NONE _____

Arthritis _____ Cancer _____ Osteoporosis _____ Problems with Anesthesia _____ Diabetes _____ Obesity _____

Other: _____

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Reviewed By: _____ Date: _____ Time: _____

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