Stacy A. Bacon, MD
Advanced Orthopaedics & Sports Medicine
(281) 955-7577
Initial Intake Questionnaire

Date: _____

Name: _____

Age: _____ **DOB:** _____ **Ht/Wt:** _____

Referring Doctor: _____ **Did you bring x-rays?** ☐ YES ☐ NO

What is the main reason for this visit? ☐ Pain ☐ Weakness ☐ Numbness ☐ Other _____

What body part is involved?							
Neck ☐	Shoulder ☐R ☐L	Elbow ☐R ☐L	Hand ☐R ☐L	Pelvis ☐R ☐L	Knee ☐R ☐L	Foot ☐R ☐L
Back ☐Mid ☐Lower	Arm ☐R ☐L	Wrist ☐R ☐L	Finger ☐R ☐L	Hip ☐R ☐L	Ankle ☐R ☐L	Toe ☐R ☐L

How long has this problem been present? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years

Check the box which best fits <u>how your problem started.</u> Then answer the <u>one</u> question below the box you checked.
Use as much space to the right as you need.

☐ **NO INJURY** **ANSWER:**
Onset was ☐ Gradual or ☐ Sudden

☐ **INJURY** (NOT AUTO OR WORK)
Date _____ Where and How it happened?

☐ **INJURY AT WORK**
Date _____ Where and How it happened?

☐ **WORK RELATED (BUT NO INJURY)**
Date _____ How did your job cause this problem?

☐ **AUTO ACCIDENT**
Date _____ Where and How was your car hit?

Please check the box below which best describes your problem:

The pain is ☐ Constant ☐ Comes and goes (intermittent)

<u>Severity</u> of pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely severe

Are there **<u>associated symptoms?</u>** ☐ Swelling ☐ Numbness ☐ Weakness

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

Does your pain awaken you from sleep? ☐ Yes ☐ No

What makes your symptoms **<u>worse?</u>** ☐ Activity ☐ Work ☐ Exercise

Which make you feel **<u>better?</u>** ☐ Rest ☐ Heat ☐ Ice ☐ Other _____

What medications have you taken or been prescribed for this problem? _____

Check which treatments you have tried: ☐ Brace ☐ PT/OT ☐ Crutch ☐ Injection

Have you been treated before for this problem? ☐ Yes ☐ No

Treating doctor: _____

MEDICATIONS: List all current medications, including over-the-counter drugs, diet supplements, and vitamins

_____

_____

DRUG ALLERGIES: _____

PAST MEDICAL HISTORY: Please check all that apply

CARDIOVASCULAR
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Arrythmia
- ☐ Pacemaker
- ☐ Heart failure
- ☐ Heart surgery

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Sleep apnea

GI
- ☐ Ulcers
- ☐ Acid reflux
- ☐ Colitis/IBD

HEPATIC
- ☐ Hepatitis
  - ☐ A ☐ B ☐ C
- ☐ Cirrhosis
- ☐ Jaundice
- ☐ Pancreatitis

RENAL
- ☐ Kidney stones
- ☐ Urinary tract infection

NEUROLOGIC
- ☐ Stroke
- ☐ TIA
- ☐ Seizures
- ☐ Multiple sclerosis
- ☐ Peripheral neuropathy

ENDOCRINE
- ☐ Diabetes
  - ☐ Insulin
  - ☐ Oral meds
  - ☐ Diet
- ☐ Thyroid disease
  - ☐ Hyper
  - ☐ Hypo
- ☐ Adrenal abnormality

CANCER

Type: _____

When: _____

MUSCULOSKELETAL
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Lupus
- ☐ Osteoporosis

PAST SURGICAL HISTORY: Please list ALL surgeries. _____

_____

FAMILY HISTORY: Please check all that apply

- ☐ Rheumatoid Arthrtis
- ☐ Osteoarthritis
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Heart attack
- ☐ Alcoholism
- ☐ Cancer
  Type: _____

SOCIAL HISTORY:

Do you smoke? ☐ YES ☐ NO Packs per day: _____

Drink alcohol? ☐ YES ☐ NO _____ drinks per ☐ day ☐ week

Marital Status? ☐ M ☐ S ☐ D ☐ W

Occupation? _____ Currently working? ☐ YES ☐ NO

How many people live with you? _____

REVIEW OF SYSTEMS: Please check all that you have experienced in the past 30days.

GENERAL
- ☐ Weight gain
- ☐ Weight loss
- ☐ Fever
- ☐ Chills

HEAD/NECK
- ☐ Blurry vision
- ☐ Sore throat
- ☐ Trouble swallowing
- ☐ Hearing loss

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Skipped heart beats

NEUROLOGICAL
- ☐ Dizziness
- ☐ Numbness/tingling
- ☐ Weakness
- ☐ Headaches

RESPIRATORY
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Coughing
- ☐ Wheezing

GI
- ☐ Abdominal pain
- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation
- ☐ Indigestion

GU
- ☐ Pain with urination
- ☐ Unable to urination
- ☐ Involuntary urination

MUSCULOSKELETAL
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Joint pain

SKIN
- ☐ Rashes
- ☐ Psoriasis

I certify that, to the best of my knowledge, all information listed above is true. I further certify that I have not misstated or intentionally omitted any information related to my health or past medical history.

Date: _____ Signature of patient/guardian: _____