Holy Cross Medical Group
Orthopedic Institute Patient Intake

General Medical History – Page 1 of 2
William Leone, MD

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 HIP/KNEE PAIN)

Medications: Do you ever use any of these medications to treat your hip/knee pain? No ___ Yes ___

Advil ___ Aleve ___ Tylenol ___ Motrin ___ Celebrex ___ Mobic ___ Ibuprofen ___ Tramadol ___

Any other medications used to treat your hip/knee pain? ____

Injections: Have you had cortisone injection(s) into your hip/knee before? ____________ Date(s): ____________________________

Have you had lubricating injection(s) into your hip/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 hip/knee? No ___ Yes ___ Date(s): ___________________

What activities does your hip/knee prevent your from doing or make difficult to do? ___________________________________

Does your hip/knee pain prevent you from performing the activities of daily living? ____________________________________

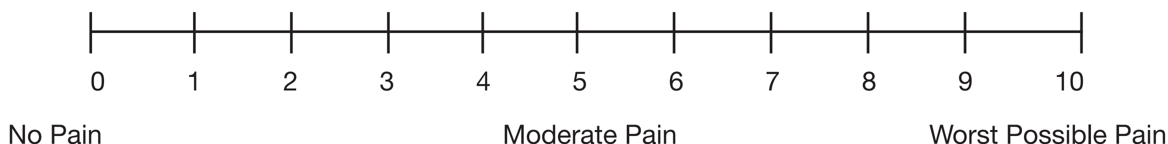
Is your hip/knee pain changing in quality? Worse ___ Better ___ Staying the same ___

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



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: ______________

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Reviewed By: ______________________________ Date: ____________ Time: ____________
Reviewed By: ______________________________ Date: ____________ Time: ____________