Lake Placid Sports Med

Patient Intake Form

General Information

Patient legal name: _____ DOB:_____ Age:_____
Name/Address of Family Physician:_____
Name/Address of Referring Physician_____

What insurance is to be billed:_____
Is your visit for a work related injury? YES or NO
Is your visit for a Motor Vehicle Accident? YES or NO Date of Accident:_____

Are you disabled? YES or NO – If YES from what? _____

Are you currently working? YES or NO
Occupation/Work:_____
RIGHT or LEFT handed

Medical Release:

The undersigned herby authorizes and requests Lake Placid Sports Medicine, PLLC, in accordance with said policies and laws, to release confidential information for the purpose of medical care, insurance payment, and disability determination.

_____Date:_____
(Signature of patient/guardian)

Financial Policy:

I have read and understand the attached financial policy for Lake Placid Sports Medicine, PLLC, and can be provided with a copy at my request through the office or at
http://www.lpsportsmed.com/page/financial-policy

_____Date:_____
(Signature of patient/guardian)

Patient Name: _____ DOB:_____

Patient Name: _____ DOB: _____

Orthopaedic Complaint:

Please focus on ***ONE*** complaint:
Reason for your visit today:

_____

Side of complaint: **RIGHT** or **LEFT** or **BILATERAL**

Symptoms started because of :

- ☐ Fall/sports injury
- ☐ Fracture/break
- ☐ Twisting injury
- ☐ Spontaneously
- ☐ Motor vehicle accident -
  Date of Accident: _____
- ☐ Work related injury –
  Date of Injury: _____
- ☐ Other
  _____

Symptoms first began (Date or year): _____
Symptoms got worse (Date or Year): _____

Describe the pain

What makes the pain worse? _____
What makes the pain better? _____

History of treatment for this problem

What other treatment(s) have you tried for this problem (check all that apply)?

- ☐ Splinting
- ☐ Injections
- ☐ Physical therapy(where?) _____
- ☐ TENS unit
- ☐ Brace/orthotic
- ☐ Surgery(when & where?) _____

List muscle relaxants, anti-inflammatories, or pain medications that you have taken for this problem:

_____

_____

_____

Have you had any of the following tests performed for this problem?

YES (provide information below) or NO

Type of test	*Date of test (approximate)*	*Location of testing center*
MRI		
Cat Scan		
Nerve conduction study/EMG		
Bone Scan		
Xray		

Patient Name: _____ DOB: _____

Past Medical/Surgical History:

Past Medical History

Check all that apply:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Asthma
- ☐ Blood clots
- ☐ Deep Vein Thrombosis
- ☐ Pulmonary Embolism
- ☐ Cancer
- ☐ Chest pain
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Gerd/Reflux
- ☐ Gout
- ☐ Heart attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Sleep Apnea
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Thyroid
- ☐ Pacemaker/AICD
- ☐ Drug abuse
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ Reaction to general/local anesthesia (excluding nausea/vomiting):_____ _____

☐ **I do NOT have any of the conditions listed above.**

Surgical History

List all ORTHOPEDIC surgeries that you have had:

Date of Surgery	*Type of ORTHOPEDIC surgery*	*Reason for ORTHOPEDIC surgery*

List all OTHER SURGERIES AND SERIOUS ILLNESSES that required hospitalization.

Date of Surgery/Illness	*Type of surgery or illness*	*Reason for surgery or hospitalization*

Family History:

Only, check those that apply to your mother, father, sister, brother or grandparents:

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Deep Vein Thrombosis
- ☐ Pulmonary Embolism
- ☐ Drug abuse
- ☐ Gout
- ☐ Other :_____
- ☐ Heart attack or Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Thyroid
- Reaction to general/local anesthesia (excluding nausea/vomiting):____

Name: _____ **DOB:** _____

Height: ____ft____in **Weight:** _____lbs

Primary Care MD: _____

Cardiologist: _____

Pharmacy Name/address: _____

No Known Drug allergies or **Allergies (medications/food) reaction:**

_____

_____

_____

Any Allergies to latex, iodine or metals: _____

Current Medications/Supplements

Name	Dose	Frequency

Social history:

Have you ever smoked: **Yes** or **No**

Current Smoker: **Yes** or **No**

Number of Cigs per day _____Quit date_____

Do you have more than two alcoholic beverages a day? **Yes** or **No**

Do you drink Caffeine daily? **Yes** or **No**

Average number of cups per day ____

Patient Name: _____ DOB: _____

Review of systems:

Please select any that you may be currently/recently experiencing

Constitutional
- ☐ Weight gain
- ☐ Weight loss
- ☐ Fever
- ☐ Fatigue

Respiratory
- ☐ Shortness of breath
- ☐ Cough
- ☐ TB exposure

Dermatology
- ☐ Contact allergy
- ☐ Rashes
- ☐ Nickel Allergy

Immunological
- ☐ Asthma
- ☐ Bee sting allergy
- ☐ Other:

_____

Gastrointestinal
- ☐ Nausea
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Jaundice
- ☐ Constipation

Metabolic
- ☐ Cold intolerant
- ☐ Heat intolerant

Head/Ears/Eyes/ Nose/Throat
- ☐ Headache
- ☐ Vertigo
- ☐ Color Blindness

Cardiovascular
- ☐ Chest pain
- ☐ Feel heart beating (palpitations)
- ☐ Fainting spells

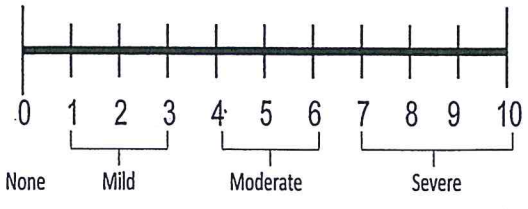
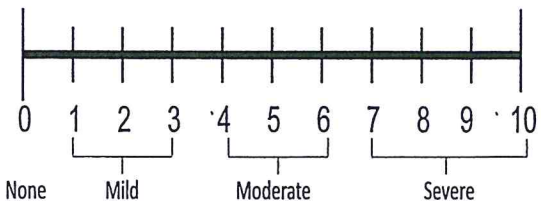
Genitourinary
- ☐ Frequency
- ☐ Urgency
- ☐ Blood in urine
- ☐ Incontinence

Neurological
- ☐ Seizures
- ☐ Numbness/tingling

Hematologic
- ☐ Easy Bruising
- ☐ Easy Bleeding

☐ **I have NONE of the symptoms listed above at this time**

Mark an "X" on the lines to show your level of pain

Rate Pain at **REST:**	Rate pain with **ACTIVITY:**
	

Reviewed by (Physician or Provider signature): _____ Date: _____