

Intake form



Main Line HealthCare
Physician Network

PATIENT INFORMATION

Name: _____

Date of Injury or Onset of Symptoms: _____

Date: _____

Family Physician, Name/Address: _____

Date of birth: _____

Current Weight: _____ Current Height: _____

Occupation and Employer: _____

Referring Physician: _____

Are you currently employed: _____

Please list all physician specialists that you are currently seeing: _____

If not when did you stop? _____

REASON FOR VISIT

PLEASE INDICATE YOUR LEVEL OF PAIN 0-10. 10 BEING THE WORST PAIN YOU HAVE EVER HAD.

1 2 3 4 5 6 7 8 9 10

Reason for your visit: _____

DRUG ALLERGIES

Please list all drug allergies and describe reaction: _____

CURRENT MEDICATIONS

Please list all medical problems with their corresponding medications (ex. Hypertension, diabetes, etc).

Medication	Associated Problems

MAIN LINE HEALTH ORTHOPAEDICS AND SPINE

Please check or fill in completely.

Social history:

- Do you drink alcohol? No Yes (Number per day _____)
Do you smoke cigarettes? No Yes (Number per day _____)

Do you have significant problems with these other areas?

- Weight loss..... No Yes
Loss of appetite..... No Yes
Fever/chills..... No Yes
Double/blurred vision..... No Yes
Ringing in ears..... No Yes
Bloody nose/gums..... No Yes
Sore throat..... No Yes
Chest pain..... No Yes
Palpitations..... No Yes
Shortness of breath..... No Yes
Cough..... No Yes
Speech..... No Yes
Leg/arm weakness..... No Yes
Blood in stool..... No Yes
Constipation/diarrhea..... No Yes
Blood in urine..... No Yes
Abdominal pain..... No Yes
Change in bladder habits..... No Yes
Rashes..... No Yes
Bruises..... No Yes
Headache..... No Yes
Dizziness..... No Yes
Blackouts..... No Yes
Numbness/tingling..... No Yes
Seizures..... No Yes
Pain in other joints?..... No Yes

If yes, please list: _____

Past medical history includes:

- High blood pressure..... No Yes
Peptic ulcer..... No Yes
Frequent infections..... No Yes
Bleeding problems..... No Yes
Stroke..... No Yes
Anesthesia problems..... No Yes
Liver disease..... No Yes
Rheumatoid arthritis..... No Yes
Cardiac disease..... No Yes
Angina..... No Yes
Thyroid..... No Yes
Diabetes..... No Yes
Sleep apnea/c-pap..... No Yes
Blood clot..... No Yes
Cancer..... No Yes
Emphysema..... No Yes
Depression/anxiety..... No Yes
Asthma..... No Yes

Other medical conditions: _____

Patient signature

Date

Mitesh P. Shah, MD

Date