Albi Qeli MD FAAOS
Orthopedic Clinic Intake Form

Please fill this form completely and accurately

Patient name	Date of birth - Age

Chief complaint (reason for today's visit)

Date of injury / onset of symptoms _____

Where were you at the time? _____

How did the injury happen? _____

Location of pain / symptoms _____

Rate your pain from 1 (mild) to 10 (absolutely unbearable) _____

Quality (aching, throbbing, burning, etc.) _____

Timing of the pain (Is the pain constant? Does it come and go? Does it happen with certain movements?) _____

Is your pain getting better, worse, or staying the same? _____

What makes your pain/symptoms better? _____

What makes your pain/symptoms worse? _____

Any burning, tingling, numbness?_____

Any snap, click, pop, clunk, tearing, ripping, grinding, or other mechanical symptoms?_____

Anything else?_____

Have you received any treatment for this condition? Please check all that apply	☐ No previous treatment ☐ I've had an injection ☐ Another orthopedist ☐ Physical therapy ☐ Pain specialist ☐ I've used a brace ☐ I have had surgery ☐ I am taking meds
Please check all that apply:	☐ Injury on the job ☐ Worker's compensation ☐ Involved in legal proceedings ☐ Receiving disability income

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Do you have any allergies? ☐ No ☐ Yes (please list your allergies and reactions below)

Drug	Type of allergy

Medical problems and medications you take ☐ Check here if none

Name of problem	Name of medication(s)	Dosage	How often?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			

Past surgeries and hospitalizations ☐ Check here if none

Name of surgery	Date	Surgeon	Hospital	Any problems?
1				
2				
3				
4				
5				
6				
7				
8				
9				

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Social history

Type of work / occupation	
Living arrangements	☐ Alone ☐ Live with parents ☐ Assisted living ☐ Live with spouse ☐ Single parent
Substance use	☐ Tobacco: _____ packs per day, for ___ years, ☐ current / ☐ quit in ____ ☐ Alcohol: _____ drinks per week ☐ current / ☐ quit in ____ ☐ Illicit drugs: _____ ☐ current / ☐ quit in ____

Family history (your relatives' medical problems) ☐ Check here if your relatives are all healthy

Mother	
Father	
Siblings	
Children	
Grandparents	

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Please rewrite your name here: _____

Review of systems

Please circle as appropriate	Please explain or write additional info in this space
General/Constitutional Feelings of fatigue, malaise, weight loss or gain, loss of strength, inability to conduct usual activities, decreased exercise tolerance, sleeplessness	
Eyes Decreased vision, double vision, dry eyes, tearing, blind spots, eye pain, blindness	
Ears, nose, throat Unusual headaches, vertigo, lightheadedness, nose bleeding, facial pain, frequent colds, dry mouth, bad teeth, tooth infection, gingival bleeding, dentures, neck stiffness, neck pain, masses / lumps, hearing loss	
Cardiovascular (heart) Coronary artery disease, irregular heart beat, chest pain, chest tightness, palpitations, shortness of breath, leg swelling, cyanosis, hypertension, heart murmurs, varicosities, phlebitis, claudication	
Respiratory (lungs) Shortness of breath, wheezing, noisy breathing, cough, bleeding, painful breathing, rapid breathing, loud snoring, spitting blood, respiratory infections, tuberculosis (or exposure to tuberculosis), fever or night sweats	
Gastrointestinal Appetite changes, difficulty swallowing, indigestion, abdominal pain, heartburn, nausea, vomiting, bleeding from the mouth, diarrhea, constipation, bleeding from below, painful bowel movement, jaundice, discolored stools, hemorrhoids, recent changes in bowel habits	
Genitourinary Burning or pain during urination, involuntary urination (accidental wetting), blood in the urine, abnormal urine color; kidney stones, infections, nephritis; excessive urination, urgency, frequency, hesitancy, change in size of stream, dribbling, genital sores, discharge, itching; irregular periods, missed periods, currently pregnant (if female)	

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Musculoskeletal Joint swelling, redness or heat, stiffness, or sensation of instability, sensation of snapping; muscle weakness, atrophy, cramps; shoulder pain, hand pain, hand burning sensations, finger catching sensation, groin pain, hip snapping, history of joint replacement, etc.	
Skin Rash, itching, changes in pigmentation or texture, changes in hair growth or loss, nail problems, nail pits, sun sensitivity	
Neurologic Convulsions, paralysis, tremor, incoordination, unstable gait; numbness, tingling, unusual sensations; difficulties with memory, slurred speech, stroke, dizziness, drowsiness	
Psychiatric Emotional problems, anxiety, depression, previous psychiatric care, unusual perceptions, hallucinations	
Hematologic Anemia, bleeding tendency, previous transfusions and reactions, Rhesus incompatibility, lumps/bumps, breast lumps, breast tenderness/swelling, nipple discharge	
Allergic, immunologic Reactions to drugs, food, insects, skin rash	
Endocrine Excessive thirst (polydipsia), hormone therapy, growth problems, problems with sexual development, intolerance to heat or cold, decreased libido	

Do you have any of the following?

☐ AIDS/HIV	☐ Diabetes	☐ Stents	☐ Major infection
☐ Hepatitis	☐ Bleeding disorder	☐ Pacemaker	☐ Kidney failure
☐ Tuberculosis	☐ Pacemaker	☐ Implants	☐ Liver failure

Please sign below Today's date