LewisGale Physicians
HCA Virginia Health System
An HCA affiliate

Date: _____

Lewis Gale Physicians Orthopedics General Intake Form

Patient Name: _____ Gender: ☐Male ☐Female

DOB: _____ Current Age: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Referred Physician: _____

Pharmacy (Name and Location):_____

How and when did your problem begin? (Please mark each answer that applies to your current pain)

☐ I don't know how it began ☐ It comes and goes ☐ I've had it for a long time (_____years)

☐ Injury (Date of Injury: _____)

On the job? ☐Yes ☐No

Have you been laid off work? ☐Yes ☐No

Are you currently involved in a lawsuit with regards to current pain? ☐Yes ☐No

Currently Employed? ☐Yes ☐No If so, where? _____ ☐Full-Time ☐Part-Time

Preview Treatment and Diagnostic Testing

Have you had any of the following for your current problem? If YES, did it make your condition better or worse? (Please Circle)			Have you had any of the following in regards to your current pain? If YES, when and where did you have them performed?		
NSAID Therapy	☐ Better	☐ Worse	Plain X-Rays	Date: _____	Where: _____
Physical Therapy	☐ Better	☐ Worse	MRI Scan	Date: _____	Where: _____
Chiropractic Care	☐ Better	☐ Worse	CT Scan	Date: _____	Where: _____
Corticosteroid Injection	☐ Better	☐ Worse	EMG / NCV (nerve test)	Date: _____	Where: _____
Other: _____	☐ Better	☐ Worse	Other: _____	Date: _____	Where: _____

Have you had previous surgery for your current pain or problem?

Type of Surgery: _____ Date: _____ Surgeon: _____

Did it make your pain (please circle): ☐ Better ☐ Worse

Have you had any other alternative forms of medical treatment that we should know about? If so, please explain:

_____

_____

Patient Initials: _____ Date: _____

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Medical History

□ Heart Attack	□ Colon Problems	□ Gout	□ Enlarged Prostate
□ Heart Murmur	□ Diabetes	□ Anxiety	□ Menstrual Problems
□ Angina	□ Hepatitis A, B, C	□ Depression	□ Cancer – Type: _____
□ High Blood Pressure	□ Cirrhosis	□ Emphysema	□ Osteoporosis
□ Stroke	□ Kidney Stones	□ Tuberculosis	□ Multiple Sclerosis
□ Varicose Veins	□ Kidney Infection	□ Chronis Bronchitis	□ Visual Changes
□ Stomach Ulcers	□ Degenerative Arthritis	□ Frequent Pneumonia	□ Blood Clots
□ Duodenal Problems	□ Rheumatoid Arthritis	□ Asthma	□ Dizziness
□ Anemia	□ Bleeding Tendency	□ Seizure Disorder	□ Other: _____
□ ALS	□ HIV	□ Tremor	

Current Medication

Medication	Reason Taken	Dose	Frequency	Prescribing Physician

Vaccination: Flu Shot: ☐Yes ☐No Date: _____ Pneumonia: ☐Yes ☐No Date: _____

Allergies

Medication / Allergen	Reaction

Surgical History

Surgery	Date

Patient Initials: _____ Date: _____

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Hospitalizations

Reason	Date

Family History

	Alive/ Deceased	Diabetes	High Blood Pressure	Asthma/ Lung Disease	Caner (type)	Heart Attack CAD	Stroke	Osteoporosis	High Cholesterol	Arthritis
Mother										
Father										
Sister										
Brother										
Son										
Daughter										

Social History

Alcohol	☐ None ☐ Occasional ____ Drinks per ☐ Day ☐ Week ☐ Month
Tobacco Use	☐ Never ☐ Current – Daily ☐ Current - Some ☐ Smokeless Tobacco – Current ☐ Former – Quit Date: _____
Caffeine	☐ Yes ☐ No If Yes, Frequency ____ Cups per Day
Illicit Drug Use	☐ Yes ☐ No
Exercise	☐ Yes ☐ No If Yes, How Many Days per Week? _____
Marital Status	☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widow/Widower
Work Status	☐ Full time ☐ Part time ☐ Disabled ☐ Retired ☐ Student
Education	☐ Grammar School ☐ High School ☐ Graduate ☐ Post-Graduate

Patient Initials: _____ Date: _____