LewisGale Physicians
HCA Virginia Health System
An HCA affiliate

Date: _____

Lewis Gale Physicians Orthopedics Urgent Care Intake Form

Patient Name: _____ Gender: ☐Male ☐Female

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

Primary Care Physician: _____ Referred Physician: _____

Pharmacy (Name and Location):_____

What are you being seen for today?_____

_____

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

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	Splint / Cast	Date: _____	Where: _____
Physical Therapy	☐ Better	☐ Worse	Reduction	Date: _____	Where: _____
Chiropractic Care	☐ Better	☐ Worse	Plain X-Rays	Date: _____	Where: _____
Corticosteroid Injection	☐ Better	☐ Worse	MRI Scan	Date: _____	Where: _____
Other: _____	☐ Better	☐ Worse	CT Scan	Date: _____	Where: _____
			EMG / NCV (nerve test)	Date: _____	Where: _____
			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:

_____

_____

What makes your pain better?

_____

_____

_____

What makes your pain worse?

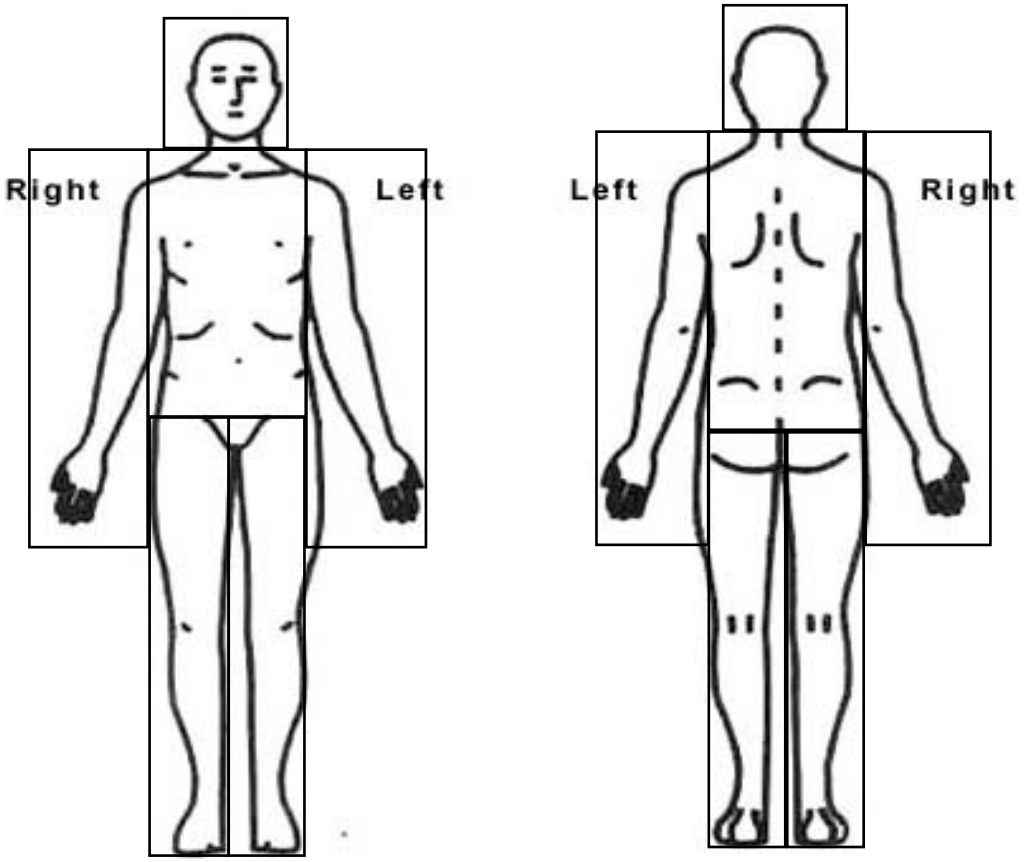
_____

_____

_____

Patient Initials: _____ Date: _____

Instructions: Please mark the below drawings according to where you are hurting or feeling pain. Please circle the area where you are having pain.



How would you rate your pain today?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain **Worst Possible Pain**

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	

Patient Initials: _____ Date: _____

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

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										

Patient Initials: _____ Date: _____

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

Review of Systems

General		**Cardiac**	
Recent weight loss of more than 10 pounds?	□ Yes □ No	Chest Pain	□ Yes □ No
Recent weight gain of more than 10 pounds?	□ Yes □ No	Shortness of Breath	□ Yes □ No
Fever?	□ Yes □ No		
Chills?	□ Yes □ No	**Pulmonary**	
Night Sweats?	□ Yes □ No	Wheezing	□ Yes □ No
Have you seen your Primary Care Physician in the last year? □ Yes □ No		Pneumonia	□ Yes □ No
		Chronic Cough	□ Yes □ No

Gastrointestinal		**Dermatological**		**Endocrine**	
Abdominal Pain	□ Yes □ No	Open Sores	□ Yes □ No	Diabetes	□ Yes □ No
Nausea	□ Yes □ No	New Moles	□ Yes □ No		
Vomiting	□ Yes □ No	Poor Healing	□ Yes □ No	**Dental**	
Diarrhea	□ Yes □ No	Skin Infection	□ Yes □ No	Significant problems	□ Yes □ No
Liver Problems	□ Yes □ No	Easy Bruising	□ Yes □ No		

Musculoskeletal		**Neurological**		**Genitourinary**	
Shoulder Pain	□ Yes □ No	Headaches	□ Yes □ No	Poor Kidney function	□ Yes □ No
Wrist/hand Pain	□ Yes □ No	Tremors	□ Yes □ No	Pain with urination	□ Yes □ No
Hip Pain	□ Yes □ No	Seizures	□ Yes □ No	Frequent UTI	□ Yes □ No
Knee Pain	□ Yes □ No	Change in vision	□ Yes □ No		
Low Back Pain	□ Yes □ No	**Psychological**		**Hematological**	
Lupus	□ Yes □ No	Sleep trouble	□ Yes □ No	Transfusion	□ Yes □ No
Muscle Weakness	□ Yes □ No	Feeling of Hopelessness	□ Yes □ No	Transplant	□ Yes □ No
Fibromyalgia	□ Yes □ No			Blood Thinner	□ Yes □ No

Patient Initials: _____ Date: _____