Date:__________

TWIN CITIES ORTHOPEDICS
Minnesota Orthopaedic Specialists

Patient Intake Form

Patient Name: ______________________________ Birth date: _________
Who referred you for this visit? ____________________________________
Primary Care Doctor and Clinic: ___________________________________
Estimated date of injury or onset of problem: _____________
Is this work related? ☐ Yes ☐ No Motor vehicle accident? ☐ Yes ☐ No
Dominant hand: ☐ Left hand ☐ Right hand ☐ Ambidextrous
Part of body being seen for today: _____________ Which side: ☐ Left ☐ Right ☐ Both

►Social History:

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partnered
Number of Children: _________ Their ages: ________________
Living Arrangements: ☐ House ☐ Townhouse ☐ Apartment or Condo ☐ Care Facility ☐ Other
Education: ☐ Grade school ☐ Some HS ☐ HS Graduate ☐ Some college/Tech school ☐ College Grad ☐ Post Grad
Employment Status: ☐ Currently Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student
Place of Employment: ______________________ Hours Per Week: ☐ 0-10 ☐ 10-20 ☐ 20-30 ☐ 30-40 ☐ 40+
Occupation and Responsibilities: ____
Hobbies and Recreational Activities (Sports, Music/Arts, Crafts): __________________________________
____
Do you smoke or use tobacco products? ☐ Yes ☐ No If so, are you interested in a cessation program? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No If so, how many drinks per week? ☐ 0 ☐ 1-6 ☐ 7-13 ☐ 14+
Have you ever been treated for substance abuse or used illegal drugs? ☐ Yes ☐ No

►Drug Allergies: ____

Do you have an allergy to tape or adhesives? ☐ Yes ☐ No Do you have an allergy to latex? ☐ Yes ☐ No

►Fall Assessment:

Are you 65 years of age or older? ☐ Yes ☐ No Have you fallen in the past year? ☐ Yes ☐ No
If so, did it result in an injury? ☐ Yes ☐ No Have you fallen 2 times in the last year? ☐ Yes ☐ No

►Review of Symptoms: Indicate any of the following symptoms you have had in the past 6 months:

Const: ☐ None ☐ Fatigue ☐ Fever ☐ Night sweats ☐ Weight gain ☐ Weight loss
Cardio: ☐ None ☐ Chest Pain/Pressure ☐ Heart Palpitations (Skipped Beats)
Skin: ☐ None ☐ Cellulitis ☐ Keloid ☐ Psoriasis ☐ Rash ☐ Redness ☐ Sores ☐ Warmth
Endo: ☐ None ☐ Excessive Thirst ☐ Obesity
GI: ☐ None ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea ☐ Vomiting
GU: ☐ None ☐ Kidney Failure ☐ Pregnancy
Hema: ☐ None ☐ Bleeding ☐ Blood Clots ☐ Bruising
MS: ☐ None ☐ Back Pain ☐ Bone Pain ☐ Decreased Range of Motion ☐ Joint Locking ☐ Joint Pain(s) ☐ Muscle Pain(s) ☐ Muscle Weakness ☐ Neck Pain ☐ Osteoporosis ☐ Shooting Pain ☐ Swelling
Neuro: ☐ None ☐ Gait Abnormality ☐ Numbness and Tingling
Psych: ☐ None ☐ Alcohol Abuse ☐ Anxiety ☐ Depression ☐ Drug Abuse ☐ Stress
Resp: ☐ None ☐ Emphysema ☐ Shortness of Breath ☐ Wheezing

►Indicate any tests or treatments that you have had for this condition (include location and year):

☐ Injection _______________________ _______ ☐ Surgery _______________________ _______
☐ X-rays _________________________ _______ ☐ MRI __________________________ _______
☐ CT/CAT Scans ___________________ _______ ☐ EMG __________________________ _______
☐ Physical Therapy ________________ _______ ☐ Other _________________________ _______

►Other Medical Problems for which you are or have been treated:

☐ Alcoholism	☐ Cardiovascular Disease	☐ Gastro Reflux (GERD)	☐ Kidney Disease	☐ Pulmonary Embolism
☐ Alzheimer's	☐ Cellulitis	☐ Heart Disease	☐ Liver Disease	☐ Rheumatoid Arthritis
☐ Anemia	☐ Cirrhosis	☐ Hepatitis	☐ Lupus	☐ Seizures
☐ Arrhythmia	☐ Deep Vein Thrombosis	☐ High Cholesterol	☐ Mental Illness	☐ Stroke
☐ Arthritis	☐ Depression	☐ High Blood Pressure	☐ MS	☐ Ulcers
☐ Asthma	☐ Diabetes	☐ Hyperthyroidism	☐ Osteoporosis	☐ Other ___________
☐ Bleeding Disorders	☐ Fibromyalgia	☐ Hypothyroidism	☐ Parkinson's	☐ Other ___________
☐ Cancer	☐ Gastritis	☐ Keloid	☐ Psoriasis	☐ Other ___________

►List any previous surgeries and note the year they were performed to the right:

☐ None	☐ Breast _______	☐ Foot _______	☐ Knee _______	☐ Tonsillectomy ______
☐ Abdominal _______	☐ Cardiac _______	☐ Gall Bladder _______	☐ Nasal _______	☐ Vascular ______
☐ Ankle _______	☐ Ear _______	☐ Hand _______	☐ Ovary _______	☐ Wrist _______
☐ Appendectomy ______	☐ Elbow _______	☐ Hip _______	☐ Prostate _______	☐ Other ________
☐ Back _______	☐ Eye _______	☐ Hysterectomy _______	☐ Shoulder _______	Year ________
☐ Bladder _______	☐ Facial _______	☐ Jaw _______	☐ Throat _______	

►Indicate primary family members (parent, brother, sister or child) with any of the following conditions:

	Primary Relative		Primary Relative
Alcoholism	☐	Hearing Loss	☐
Allergies	☐	Heart Disease	☐
Alzheimer's Disease	☐	High Cholesterol	☐
Anemia	☐	Hypertension	☐
Arthritis	☐	Hyperthyroidism	☐
Asthma	☐	Hypothyroidism	☐
Bleeding Disorders	☐	Kidney Disease	☐
Breast Cancer	☐	Lupus	☐
Cancer	☐	Mental Illness	☐
Cardiovascular Disease	☐	MS	☐
Cerebrovascular Disease	☐	Osteoporosis	☐
Crohn's Disease	☐	Parkinson's Disease	☐
Degenerative Joint Disease	☐	Prostate Cancer	☐
Depression	☐	Rheumatoid Arthritis	☐
Diabetes	☐	Seizures	☐
Eczema	☐	Skin Cancer	☐
Epilepsy	☐	Stroke	☐
Gastro Reflux (GERD)	☐	Ulcerative Colitis	☐

☐ I have received the HIPPA Privacy Practice Act from Minnesota Orthopaedic Specialists, P.A.

Patient Signature: ______________________________________ Date: _________________________

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Current Medications

Patient Name: ___________________________________ Birth date: __________

► **List any current medications you are taking:**

Anti Depressant:
- Effexor (venlafaxine)
- Cymbalta (duloxetine)
- Prozac (fluoxetine)
- Paxil (paroxetine)
- Wellbutrin (bupropion)
- Zoloft (sertraline)

Anti Ulcer:
- Prilosec (omeprazole)
- Prevacid (lansoprazole)
- Nexium (esomeprazole)
- Protonix (pantoprazole)
- Tagamet (cimetidine)
- Zantac (ranitidine)

Allergy/Asthma:
- Allegra (fexofenadine)
- Claritin (loratadine)
- Singulair (montelukast)
- Zyrtec (cetirizine)
- Albuterol Inhaler
- Asthma-Steroid Inhaler (any brand)

Blood Thinners:
- Aspirin
- Coumadin (warfarin)
- Refludan (lepirudin)
- Ticlid (ticlopidine)
- Plavix (clopidogrel)
- Aggrastat (tirofiban)
- Integrilin (eptifibatide)

Cholesterol Lowering:
- Lipitor (atorvastatin)
- Zocor (simvastatin)
- Crestor (rosuvastatin)
- Mevacor (lovastatin)
- Niaspan (niacin)
- Gemfibrozil
- Zetia

Diabetes:
- Insulin Injections (any type)
- Glucophage (metformin)
- DiaBeta, Glynase or Micronase (glyburide)
- Glucotrol (glipizide)
- Glucagon
- Avandia (rosiglitazone)
- Precose (acarbose)

Cardiac/Hypertension:
- Capoten (captopril)
- Lisinopril
- Cozaar (losartan)
- Diovan (valsartan)
- Dyazide (hydrochlorothiazide)
- Nifedipine
- Verapamil
- Diltiazem
- Norvasc (amlodipine)
- Inderal (propranolol)
- Tenormin (atenolol)
- Lopressor (metoprolol)
- Coreg (carvedilol)
- Toprol

Pain Medications:
- Darvocet
- Fentanyl
- Hydrocodone
- Lyrica
- MS Contin
- Neurontin
- Oxycodone
- OxyContin
- Percocet
- Tylenol #3
- Vicodin
- Vistaril
- Zanaflex

Antibiotics:
- Amoxicillin
- Augmentin (amoxicillin/potassium)
- Bactrim (trimethoprim)
- Biaxin (clarithromycin)
- Cipro
- Cleocin (clindamycin)
- Doxycycline
- Erythromycin
- Keflex (cephalexin)
- Levaquin (levofloxacin)
- Lamisil (terbinafine hydrochloride)
- Sporanox (itraconazole)
- Zithromax (azithromycin)

Anti Inflammatory:
- Acetaminophen (Tylenol)
- Celebrex
- Naproxen (Aleve)
- Ibuprofen
- Prednisone

Osteoporosis Treatment:
- Actonel
- Fosamax
- Boniva

Reproductive:
- Birth Control Pills
- Depo-Provera Injections
- Hormone Replacement (estrogen/progestin)

Other:

____________________ ____________________ ____________________