OFFICE USE ONLY
☐ Fax to: OR Control 419-520-2831
☐ For Joint Replacement and Inpatient Spine Procedures OR Control to fax to:
Occupational Therapy: 419-526-8634
Physical Therapy: 419-526-8382
Social Service: 419-526-8063
PST Date_____ Time_____
Surgery Date_____ Approach_____
MRSA Swab obtained in office YES ☐ NO☐

OhioHealth Orthopedic & Sports Medicine Physicians

335 Glessner Avenue, Mansfield, Ohio 44903

PATIENT INTAKE ASSESSMENT

FILL IN CIRCLES COMPLETELY IF YES

Name: _____ Today's Date: _____

Address: _____City: _____Zip: _____

Occupation: _____ Age: _____ Height: _____ Weight: _____
(BMI: _____ to be completed by office nurse)

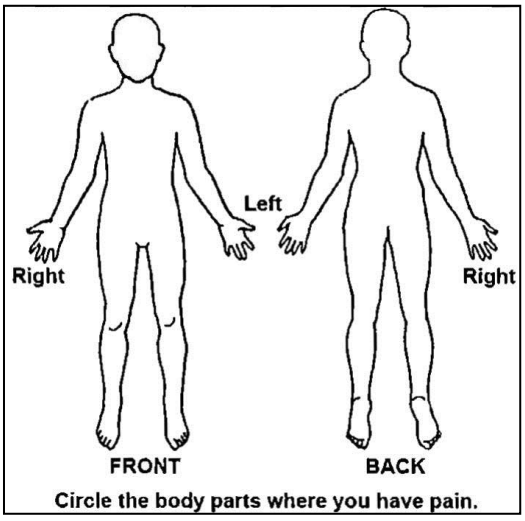
How did you get referred to this office? _____

Primary Care Physician: Name: _____

REASON FOR TODAY'S VISIT: _____

HISTORY OF PRESENT ILLNESS THAT BRINGS YOU HERE TODAY:

Do you have pain? O Yes Where is the location of your pain? _____
When did it start?_____How long have you had this pain? _____
Rate your pain on a scale of 0 to 10 (10 being the most painful): _____
Is the pain: O Constant O Occasional O Sharp O Dull O Aching
O Stabbing O Throbbing
What, if anything, makes your pain *better*? _____
What, if anything, makes your pain *worse*? _____
What other symptoms are you experiencing?_____



Circle the body parts where you have pain.

Have you seen another physician for this problem? O Yes
If yes, who?_____

What treatments have you tried?
O Physical Therapy O Exercise O Acupuncture O Chiropractic
O Massage O Injections O Medications

What type of exercise or activities or hobbies do you enjoy?_____

Patient Name: _____ ***FILL IN CIRCLES COMPLETELY***

Do you have difficulty putting on or taking off your shoes and socks? Please check: O Yes
Do you use assistive devices to walk? Please check: O None O Walker O Cane O Crutches
How far can you walk? Please Check:
O 0-2 City Blocks O 3-6 City Blocks O 7-12 City Blocks O Unlimited

MEDICAL HISTORY:

O None O Irregular Heartbeat O High Blood Pressure O High Cholesterol O Heart Disease O Blood Clots
O Cancer O Diabetes O Asthma O Emphysema O Strokes O Seizures O Liver Disease O Rheumatoid Arthritis
O Osteoarthritis O Thyroid Disease O Anemia O Heart Attack O HIV O Chemical O Alcoholism O Depression
O Hepatitis B or C O Chemical O Kidney Disease O Other_____

Are you followed by a cardiologist? O Yes Your cardiologist's name:_____
Phone: (____) _____

Are you followed by any other specialist? O Yes Name_____ Specialty:_____
Phone: (____) _____

GASTROINTESTINAL History
Do you have a history of a stomach ulcer (peptic ulcer disease)? O Yes If yes, when: _____
Do you take any medications for your stomach? Please include over the counter medications: i.e., Pepsid, Tums, Zantac, etc.) _____

PAST SURGICAL HISTORY: *FILL in circle completely and note date*

Surgery	Date	Surgery	Date
O No prior surgery		O Prostate	
O Bowel Removal		O Thyroid	
O Head/Brain		O Lower Back	
O Kidney/Stone		O Hysterectomy	
O Cataract Right		O Hemorrhoid	
O Cataract Left		O Lung	
O Heart/Bypass		O Fracture	
O Appendix		O Gall Bladder	
O Vascular		O Stomach	
O Skin		O Other	

Patient Name: _____ ***FILL IN CIRCLES COMPLETELY***

MEDICATIONS: Please list **ALL** medications you are currently taking **or provide list to nurse.** Please include antibiotics, blood thinners, insulin, heart medications, aspirin, and any other over-the-counter medications including vitamins, minerals and herbal supplements.

Medication	Dosage	Frequency	Reason for Medication

ALLERGIES: Please check: O No known drug allergies,

Allergic to: O **Penicillin** O **Sulfa** O **Latex** Other_____

Type of Reaction to Allergy:_____

Please list all other allergies: _____

SLEEP APNEA EVALUATION: (Fill in circle completely if yes)

Have you had recent weight gain of more than 15 lbs in the past year? O Yes

Have you ever been seen by a sleep specialist? O Yes If yes, name of doctor: _____

Have you ever had a sleep study done? O Yes If yes, what lab? _____

Have you ever been prescribed APAP, or BiPAP? O Yes

Have you ever been prescribed oxygen? O Yes

Do you snore? O Yes

Do you snore loudly? O Yes

Have you ever been told that you stop breathing when you sleep? O Yes

Are you tired, sleepy or fatigues during the day? O Yes

Do you wake up mornings with a headache? O Yes

Patient Name: _____ ***FILL IN CIRCLES COMPLETELY***

SOCIAL HISTORY: (only check if yes)

Do you live alone? O Yes Who lives with you? _____

Do you have Children? O Yes How many _____

Occupation? _____ What type of work do you do? _____

Do you have stairs in the home? O Yes

How many stairs do you have to climb to enter the home? _____

Tobacco use? O Yes Number of packs per day: _____ Duration: _____ Quit date: _____

Alcohol use? O Yes Frequency: _____

Recreational drug use? O Yes Frequency: _____

What services do you currently receive in the home?

Meals on Wheels ? O Yes Home Health Care? O Yes Name: _____

Senior programs? O Yes Name(s): _____

Do you have transportation to go to outpatient therapy if needed? O Yes

What equipment do you have at home? O Walker O Crutches O Commode Chair O Shower Chair/Bench

Other: _____

FAMILY HISTORY: (please note next to condition if Father, Mother or Sibling)

Condition	Father/Mother/Sibling	Condition	Father/Mother/Sibling
O Heart Disease		O Diabetes	
O Blood Clots		O Cancer	
O Hypertension		O Stroke	
O Seizures		O Respiratory (chronic cough)	
O Other			

REVIEW OF SYSTEMS: Please fill in circle completely if you have any of the following **current symptoms or current known medical** problems in the following areas:

CONSTITUTIONAL:

O None

O Weight Loss O Weight Gain O Insomnia O Chronic Fatigue O Fever

EYES:

O None

O Recent vision change O Cataracts O Glaucoma O Any history of metal fragments in the eye?

EARS, NOSE, THROAT:

O None

O Loss of Hearing O Seasonal Allergies O Hearing aids

O Dental issues_____

Patient Name: _____ ***FILL IN CIRCLES COMPLETELY***

HEART:

O None

O Chest pain O Angina O Hypertension O Heart Murmur O Irregular pulse O Palpitations

O Shortness of Breath O High Cholesterol O High Triglycerides O Bypass Surgery O Pacemaker

O Stent

RESPIRATORY:

O None

O Asthma O Wheezing O Shortness of Breath O Pneumonia or Bronchitis O Emphysema/COPD

O Sleep Apnea

Date and location of last chest x-ray: _____

GASTROINTESTINAL:

O None

O Heartburn O Indigestion O Acid Reflux O Ulcer O GI, Stomach Bleed O Blood in Stools

O Colon Cancer Constipation O Diarrhea

SKELETAL:

O None

O Arthritis O Muscle Weakness O Joint Pain O Back Pain O Fibromyalgia

O Reflex Sympathetic Dystrophy O Joint Replacement O Bone Infection O Swelling Multiple Joints

SKIN:

O None

O Chronic Rash O Ulcers O Eczema O Psoriasis O Skin Cancer or Melanoma

NEUROLOGICAL:

O None

O Numbness O Weakness or loss of sensation in arms or legs O Leg pain/Sciatica

O Loss of Bowel or Bladder Control O Seizures O Headaches

PSYCHIATRIC:

O None

O Depression O Anxiety O Claustrophobia O Other Psychiatric Problems

ENDOCRINE:

O None

O Diabetes O Hypothyroid O Hyperthyroid O Hot Flashes O Hormone Replacement

O Taken Prednisone

Patient Name: _____ ***FILL IN CIRCLES COMPLETELY***

HEMATOLOGY:

O None

O Anemia O Easy Bruising O Easy Bleeding O Blood Transfusion, When_____

GYNECOLOGICAL:

O None

O Breast Cancer O Ovarian Cancer O Cervical Cancer O Fibroid Tumors

GENITOURINARY:

O None:

O Bladder Infections O Blood in Urine O Difficulty with Urination O Kidney Stones

O Prostate Problems O Urgency O Hesitancy O Nocturia (urinating during the night)

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

PHYSICIAN SIGNATURE_____ DATE: _____