Intake form

Main Line HealthCare
Physician Network

PATIENT INFORMATION

Name:_____

Date: _____

Date of birth: _____

Current Weight: _____ Current Height: _____

Occupation and Employer: _____

_____

Are you currently employed:_____

If not when did you stop? _____

Date of Injury or Onset of Symptoms: _____

Family Physician, Name/Address: _____

_____

_____

Physician who sent you here: _____

Please list all physician specialists that you are currently seeing: _____

_____

_____

REASON FOR VISIT

Please explain **which side, how** and **when** things began, describe your symptoms and severity, **what** makes your symptoms better or worse, are things getting any better or worse, any **tests** or **treatment** you may have had for this problem, etc.

Reason for your visit:_____

_____

_____

_____

CURRENT MEDICATIONS

Please list all medical problems with their corresponding medications (ex. Hypertension, diabetes, etc).

Medication	Associated Problems

DRUG ALLERGIES

Please list allergies to medications: (describe reaction for each): _____

_____

_____

Are you allergic to take, iodine, or latex?

_____

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MAIN LINE HEALTH ORTHOPAEDICS AND SPINE

Please check or fill in completely.

Please list all major surgeries you have had, including dates and side (left or right):

_____

_____

_____

Social history:

Do you smoke cigarettes? ☐ No ☐ Yes (Number per day)

Have you ever smoked? (how much and for how long) _____

_____

If yes, when did you quit?_____

Do you drink? ☐ No ☐ Yes

Have you ever had a drug or alcohol problem? _____

_____

Please list all major diseases that run in your family:

_____

_____

_____

_____

Review of Systems (please explain all YES answers).

Have you ever had a problem taking aspirin, Motrin, or other arthritis type medication?

_____

Have you had a history of recent fevers, sweats, chills, or weight loss?

_____

Have you had any problems with your heart or blood pressure?

_____

Have you had any problems breathing or lung problems (ex: asthma, emphysema, cough, etc)?

_____

Have you had any problems with digestion or bowel problems?

_____

Have you had any problems with kidney or bladder function (ex: kidney stones, problems with urination)?

_____

Have you had any problems with other joint or muscles? (arthritis, gout, osteoporosis, etc)?

_____

Have you had any problems with your skin? (rashes, etc)?

_____

Have you had any neurological problems (ex: stroke, seizure, dizziness, nerve, or headache)?

_____

Have you had any endocrine (hormonal) problems such as diabetes (sugar, thyroid, etc)?

_____

Have you had any problems with anemia, bleeding, or other blood problems?

_____

Do you have a history of intestinal bleeding?

_____

Do you have any liver problems (hepatitis, jaundice, etc)?

_____

Have you had any problems with your eyes, ears, nose, throat, or mouth?

_____

Please list any other health problems not already mentioned

_____

_____

_____

Patient signature Date

_____

Christopher R. Kester, DO Date