HCA MIDWEST HEALTH
KANSAS CITY JOINT REPLACEMENT

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NEW PATIENT INTAKE FORM

Date_____

NAME _____

Age _____ Gender ☐ MALE ☐ FEMALE

Who referred you?_____

History of Present Illness (circle all that apply and/or describe in space provided)

Complaint: _____

Duration of symptoms: ☐YEARS ☐MONTHS ☐WEEKS ☐DAYS

How often are the symptoms present? ☐DAILY ☐WEEKLY ☐VARIABLE _____

History of injury or surgery to affected body part? ☐NO ☐YES

Location of symptoms:

Knee: ☐FRONT ☐INNER ☐OUTER ☐BEHIND KNEE ☐ALL OVER

Hip: ☐GROIN ☐OUTSIDE ☐BUTTOCK ☐LEG ☐BACK/SPINE ☐ALL OVER

Quality: ☐DULL (ACHY) ☐SHARP ☐CATCHING/LOCKING ☐OTHER _____

Associated symptoms: ☐LIMP ☐STIFFNESS ☐WEAKNESS ☐NIGHT PAIN ☐UNSTABLE
☐STARTING UP TO WALK ☐OTHER _____

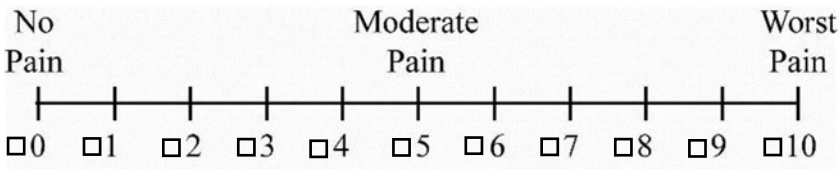
Difficulties: ☐STAIRS ☐IN/OUT OF CHAIR or CAR ☐TYING SHOES/SOCKS ☐OTHER _____

Present activity level: ☐NO LIMITATIONS ☐WALK > 1 MILE/DAY ☐DAILY WALKING (town, house, office)
☐INDOOR WALKING ONLY ☐SEVERELY LIMITED (only move bed to chair)

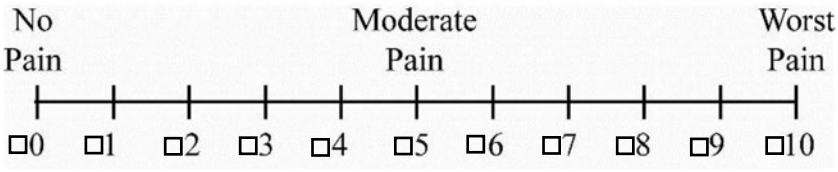
Treatments: ☐MODIFIED ACTIVITY ☐CANE/WALKER/WHEELCHAIR ☐BRACING ☐PHYSICAL THERAPY
☐ANTI-INFLAMMATORY MEDICATION (Tylenol, Ibuprofen, Aleve, etc.) ☐PAIN MEDICATION
☐STEROID INJECTION(S) ☐OTHER INJECTION(S) _____

Prior surgical consultation? NO☐ YES☐ (If so, was surgical treatment recommended? NO☐ YES☐

Pain on your WORST days:



Pain on your BEST days:



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PAST MEDICAL HISTORY

Are you now or have you ever been treated for any of the following:

	Yes	No	Explain:
High Blood Pressure			
Diabetes			
Cancer			
Heart Problems			
Chest Pain			
Asthma			
Epilepsy/Seizure			
Stroke			
Thyroid			
Bleeding Disorder			
Hepatitis			
Jaundice			
AIDS/HIV			

Have you had previous surgeries? Please list: _____

Are you allergic to medicine, tape, or iodine? Please list: _____

Are you taking medication? Please list or provide copy of present medication list: _____

	YES	NO	
Do you smoke?			If yes, how much per day? _____
Did you smoke previously?			If yes, stop date? _____
Do you drink alcohol?			If yes,how much a week? _____
Have you had a flu vaccination in the past 12 months?			If yes, please put the date and location: _____
Do you have an Advance Directive or living will?			If yes, provide copies to our office.

FAMILY HISTORY:

Is there any family history of health problems such as:

	Yes	No	Explain:
Diabetes			
Cancer			
High Blood Pressure			
Stroke			
Other			

REVIEW OF SYSTEMS

Do you have any complaints with: Indicate with Y or N

Sleep____ Eyes____ Heart____ Lungs____ Bowels____ Bladder____ Skin____
Headaches____ Allergies____ Depression/Anxiety____ Weight Loss/Gain____ Numbness/Tingling____
Please explain: _____

_____

_____