Ortho Nebraska

2725 South 144th Street, Suite #212
Omaha, NE 68144
phone: (402) 609-3000
fax: (402) 609-3808

Hip Intake Form - Dr. Burt

Patient Name	Date of Birth	Height	Weight
Appointment Date	**Referring Physician**	**Family Physician**	**Pharmacy**

Are you a competive athlete? ○ Yes ○ No
If yes, list primary sport _____
Is this a Workmen's Compensation Claim? ○ Yes ○ No
Which hip is bothering you? ○ Left ○ Right ○ Both
How long has this bothered you? ___Days ___Weeks ___Months ___Years
Did you have a specific injury? ○ Yes ○ No
If yes, describe the injury _____
If yes, list date of injury _____
Are your symptoms? ○ Better ○ Worse ○ Same
Location of Pain ☐ Groin or bikini line ☐ Front of thigh ☐ Side of Hip ☐ Buttock
How would you describe your pain?
☐ Dull ☐ Burning ☐ Sharp/Shooting ☐ Stabbing ☐ Other _____
Rate your pain on a scale of 1 to 10, 10 being the worst: _____
Is your pain? ○ Constant ○ Intermittent
What makes your symptoms worse?
☐ Driving ☐ Prolonged Sitting ☐ Standing ☐ Walking ☐ Running ☐ Pivoting/twisting
☐ Exercise ☐ Rotational Movement ADLs ☐ Sleeping ☐ Putting shoes/socks on
Other _____
What makes your symptoms better? _____
Do you have any of the following symptoms?
☐ Giving way ☐ Catching/pinching sensation ☐ Painful popping ☐ Painless popping
Have you tried any of the following treatment?
Medications (over the counter and prescription): _____
Injection
☐ Bursa injection _____ Was it helpful? _____
☐ Intraarticular injection _____ Was it helpful? _____
Physical Therapy _____ Was it helpful? _____
Surgery _____ Was it helpful? _____
Have you had any of the following test? If yes, please indicate when and where:
Xrays: _____
MRI: _____
Please list any current medications, both over-the-counter and prescription:

_____

_____

Please list any medical allergies:

_____

_____

TURN OVER FOR PAGE 2

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Pharmacy Name & Address/Streets: _____ Phone Number: _____

Social History Do you use any of the following? (check all that apply)

Smoking or Smokeless Tobacco	☐ Never	☐ Current	☐ Former	(Date Quit: _____)
Electronic Cigarette/Vaping	☐ Never	☐ Current	☐ Former	(Date Quit: _____)
Alcohol	☐ Never	☐ Current (1-2 times per ☐ Week ☐ Month ☐ Year)		☐ Former

Non-prescription, mind-enhancing or performance enhancing drugs (please list): _____

Family History

Anesthesia Problems	☐ Father	☐ Mother	☐ Brother	☐ Sister
Cancer	☐ Father	☐ Mother	☐ Brother	☐ Sister
Bleeding/Clotting (DVT)	☐ Father	☐ Mother	☐ Brother	☐ Sister
Diabetes	☐ Father	☐ Mother	☐ Brother	☐ Sister
Gout	☐ Father	☐ Mother	☐ Brother	☐ Sister
Heart Disease	☐ Father	☐ Mother	☐ Brother	☐ Sister
High Blood Pressure	☐ Father	☐ Mother	☐ Brother	☐ Sister
Stroke	☐ Father	☐ Mother	☐ Brother	☐ Sister

Procedure History (Please list all)

☐ None ☐ Appendectomy
☐ Heart Bypass: (date) _____ ☐ Sinus
☐ Tubal Ligation ☐ C-Section ☐ Hysterectomy
☐ Stent Placement: (date) _____ ☐ Tubes (Ear)
☐ Gall Bladder ☐ Pacemaker ☐ Tonsils
☐ Vasectomy ☐ Other
☐ Orthopaedic: (procedure & date):
_____

Past Personal Medical History

☐ Anxiety	☐ Depression	☐ HIV	☐ Pulmonary Embolism
☐ Asthma	☐ Diabetes	☐ Kidney Disease	☐ Reaction to Anesthesia
☐ Blood Clots/DVT	☐ Fibromyalgia	☐ Liver Disease	☐ Sleep Apnea/C-PAP
☐ Blood Disorder	☐ Gastric Ulcer	☐ Lung Disease	☐ Staph
☐ Cancer	☐ Gout	☐ MRSA	☐ Stroke
☐ Cellulitis	☐ Heart Disease	☐ Multiple Sclerosis	☐ Thyroid Disorder
☐ Claustrophobia	☐ Hepatitis A/B/C (circle one)	☐ Osteoarthritis	☐ Other _____
☐ Dementia	☐ High Blood Pressure	☐ Osteoporosis	☐ Other _____

Immunizations

Influenza Vaccine	☐ Yes (if yes, when? _____)	☐ No	☐ Unknown
Pneumococcal Vaccine	☐ Yes (if yes, when? _____)	☐ No	☐ Unknown
COVID-19 Vaccine	☐ Yes (if yes, ☐ Series started ☐ Series ended)	☐ No	☐ Unknown

Patient/Guardian Signature: _____ **Date:** _____