Ortho Nebraska

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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:

_____

_____

Did you receive the influenza vaccine this season? Yes No
Have you been discharged from a nursing facility, hospital or skilled rehabilitation facility in the last 30 days? Yes No

Social History

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

Smoking Tobacco ☐ Never ☐ Current ☐ Former (Date Quit: _____)

Smokeless Tobacco ☐ Never ☐ Current ☐ Former (Date Quit: _____)

Electronic Cigarette/Vaping ☐ Never ☐ Current ☐ Former (Date Quit: _____)

Alcohol ☐ Current (1-2 times per ☐ Week ☐ Month ☐ Year) ☐ Past ☐ Never

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

Do you exercise regularly? ☐ Yes ☐ No How many times per week? ☐ Daily ☐ 1-2 ☐ 3-4 ☐ 5-6

Employer: _____ ☐ Retired ☐ Disabled ☐ Unemployed

What kind of work do you do? _____

Are you a student? ☐ Yes ☐ No If yes, please list your grade and school name: _____

Family History (Please check where applicable)

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

Past Medical History (Check all that apply)

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

Procedure History (Please list all past procedures)

☐ None

☐ Orthopaedic: (procedure & date) _____

☐ Stent Placement: (date) _____ ☐ Heart Bypass: (date) _____

☐ Pacemaker ☐ Hysterectomy ☐ Appendectomy ☐ Gall Bladder ☐ Sinus

☐ C-Section ☐ Tubal Ligation ☐ Tonsils ☐ Tubes (Ear) ☐ Vasectomy

☐ Other: _____

Review of Systems (Please mark current systems)

Constitutional
☐ Normal ☐ Night Sweats
☐ Chills ☐ Obesity
☐ Fever ☐ Weight Change

HEENT
☐ Normal ☐ Tooth Pain
☐ Headache ☐ Visual Problems
☐ Hearing Loss

Respiratory
☐ Normal
☐ Shortness of Breath

Cardiovascular
☐ Normal
☐ Chest Pain
☐ Difficulty Breathing

Gastrointestinal
☐ Normal ☐ Vomiting
☐ Heartburn/Acid Reflux
☐ Nausea

Genitourinary
☐ Normal
☐ Urinary Frequency
☐ Urinary Incontinence

Hema/Lymph
☐ Normal ☐ Bruises Easy
☐ Bleeds Easy

Endocrine
☐ Normal ☐ Excessive Thirst
☐ Excessive Sweating

Immunologic
☐ Normal ☐ Swollen Neck Glands
☐ Seasonal Allergies

Musculoskeletal
☐ Normal
☐ Other Joint Pain

Integumentary
☐ Normal
☐ Rash
☐ Skin Lesions

Neurologic
☐ Normal ☐ Tingling
☐ Motor Disturbances ☐ Vertigo/Dizziness
☐ Numbness

Psychiatric
☐ Normal ☐ Depression
☐ Anxiety

Health Promotion

Have you been discharged from a nursing facility, hospital or skilled rehabilitation facility in the last 30 days? ☐ Yes ☐ No

If you are 64 years of age or older, please answer the below questions:

Advanced Care Planning

Do you have an Advance Directive?	☐ Yes	☐ No
Are you providing a copy of your Advance Directive at your visit?	☐ Yes	☐ No
Are you interested in receiving additional information on Advance Directives?	☐ Yes	☐ No

Fall Prevention

Are you non-ambulatory (wheelchair bound or bedridden)?	☐ Yes	☐ No
Have you Fallen in the past year?	☐ Yes	☐ No
If yes, how many times? _____		
If yes, were you injured?	☐ Yes	☐ No
Do you feel unsteady standing or walking?	☐ Yes	☐ No
Do you worry about falling?	☐ Yes	☐ No

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

OFFICE USE

☐ Fall Education Offered ☐ Reviewed/Entered By _____
☐ Advance Directive Information Provided