INTAKE QUESTIONNAIRE FORM

ENLOE

Please provide us with the following information.
We will enter this information into your electronic health record.
Please bring a current medication list or all medications to your office visit. TODAY'S DATE _____

PATIENT DEMOGRAPHICS

Name *(last, first, middle initial)*			SS#
Gender: ❑ Male ❑ Female	Birth date: / /	Aliases:	
Physical Address	City	State	Zip
Mailing Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Mobile ( )	
Email Address		Primary Phone: ❑ Home ❑ Mobile	

GENERAL INFORMATION

Marital Status: ❑ Divorced ❑ Legally separated ❑ Married ❑ Single ❑ Widowed ❑ Significant other			Birth State
Interpreter Needed: ❑ Yes ❑ No	Preferred Language		
English Fluency: ❑ Good ❑ Not at all ❑ Not good ❑ Very good		Written Language	
Ethnicity: ❑ Mexican American or Chicano ❑ Cuban	❑ Other Hispanic, Latino/a, or Spanish Origin ❑ NOT Hispanic, Latino/a, or Spanish Origin		❑ Puerto Rican ❑ Decline to answer
Religion	Military Status & Branch		Race

EMERGENCY CONTACT

Contact Name			Primary Phone: ❑ Home ❑ Mobile
Home Phone ( )	Work Phone ( )	Mobile ( )	
Contact Address	City	State	Zip
Contact Email	Relationship to Patient		
Legal Guardian? ❑ Yes ❑ No			
Secondary Contact			Primary Phone: ❑ Home ❑ Mobile
Home Phone ( )	Work Phone ( )	Mobile ( )	
Contact Address	City	State	Zip
Contact Email	Relationship to Patient		
Legal Guardian? ❑ Yes ❑ No			

PATIENT QUESTIONNAIRE

ENLOE
TOTAL JOINT REPLACEMENT PROGRAM

PATIENT NAME_____ **DATE OF BIRTH**_____

What are we seeing you for today? **Right** **Left** **Knee** **Hip**

Pain scale 1-10? _____

When did the problem start? _____

How did the problem start? _____

Describe the symptoms: (sharp pain, dull ache, numbness, tingling, etc.)

_____

Describe the severity: (mild, moderate, severe, disabling, etc.)

_____

Duration of symptoms: (hours, days, months, years, intermittent, etc.)

_____

Timing of symptoms: (with activity, at night, while typing, etc.)

_____

What makes the problem better? (Rest, heat, ice, medications, etc.)

_____

What makes the problem worse? (Activity, reaching overhead, lifting, etc.)

_____

How far can you tolerate to walk? _____

Do you struggle to put your sock on or tie your shoe on the affected side? **Yes** **No**

Does you hip/knee pain interupt your sleep? **Yes** **No**

Previous treatment for this problem:

Injections_____ Physical Therapy_____ Medication_____ Surgery_____

Metal allergies? (Necklaces, earrings, etc.)_____ **Known metal:**_____

Allergies to latex or iodine?_____

Review of Symptoms

ENLOE

Patient Name *(last, first, middle initial)*_____ **Date of Birth**_____

PLEASE CHECK ALL THAT APPLY

Constitution
- ❑ Activity change
- ❑ Appetite change
- ❑ Chills
- ❑ Diaphoresis (Sweating)
- ❑ Fatigue
- ❑ Fever
- ❑ Unexpected weight change

HENT
- ❑ Congestion
- ❑ Dental problem
- ❑ Drooling
- ❑ Ear discharge
- ❑ Ear pain
- ❑ Facial swelling
- ❑ Hearing loss
- ❑ Mouth sores
- ❑ Nosebleeds
- ❑ Postnasal drip
- ❑ Rhinorrhea (runny nose)
- ❑ Sinus pain
- ❑ Sinus pressure
- ❑ Sneezing
- ❑ Sore throat
- ❑ Tinnitus (ringing in ears)
- ❑ Trouble swallowing
- ❑ Voice change

Eyes
- ❑ Eye discharge
- ❑ Eye itching
- ❑ Eye pain
- ❑ Eye redness
- ❑ Photophobia (sensitive to light)
- ❑ Visual disturbance

Respiratory
- ❑ Apnea
- ❑ Chest tightness
- ❑ Choking
- ❑ Cough
- ❑ Shortness of breath
- ❑ Stridor
- ❑ Wheezing

Cardiovascular
- ❑ Chest pain
- ❑ Leg swelling
- ❑ Palpitations

GI
- ❑ Abdominal distention
- ❑ Abdominal pain
- ❑ Anal pain
- ❑ Blood in stool
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Rectal pain
- ❑ Vomiting

Endocrine
- ❑ Cold intolerance
- ❑ Heat intolerance
- ❑ Polydipsia (increased thirst)
- ❑ Polyphagia (increased appetite)
- ❑ Polyuria (increased urination)

GU
- ❑ Difficulty urinating
- ❑ Dyspareunia (painful sexual intercourse)
- ❑ Dysuria (painful urination)
- ❑ Enuresis
- ❑ Flank pain
- ❑ Frequency
- ❑ Genital sore
- ❑ Hematuria (blood in urine)
- ❑ Menstrual problem
- ❑ Penile discharge
- ❑ Penile pain/swelling
- ❑ Pelvic pain
- ❑ Scrotal swelling
- ❑ Testicular pain
- ❑ Urgency
- ❑ Urine decreased
- ❑ Vaginal bleeding
- ❑ Vaginal discharge
- ❑ Vaginal pain

Muscular
- ❑ Athralgias (joint pain)
- ❑ Back pain
- ❑ Gait problem
- ❑ Joint swelling
- ❑ Myalgias (muscle pain)
- ❑ Neck pain
- ❑ Stiffness

Skin
- ❑ Color change
- ❑ Pallor
- ❑ Rash
- ❑ Wound

Allergy/Immuno
- ❑ Environmental allergies
- ❑ Food allergies
- ❑ Immunocompromised

Neurological
- ❑ Dizziness
- ❑ Facial asymmetry
- ❑ Headaches
- ❑ Light-headedness
- ❑ Numbness
- ❑ Seizures
- ❑ Speech difficulty
- ❑ Syncope (fainting)
- ❑ Tremors
- ❑ Weakness

Hematologic
- ❑ Adenopathy (swollen lymph nodes)
- ❑ Bruises/bleeds easily

Psychiatric
- ❑ Agitation
- ❑ Behavior problem
- ❑ Confusion
- ❑ Decreased concentration
- ❑ Dysphoric mood
- ❑ Hallucinations
- ❑ Hyperactive
- ❑ Nervous/anxious
- ❑ Self injury
- ❑ Sleep disturbance
- ❑ Suicidal ideas

❑ Other symptoms_____

_____

_____

_____

_____

PRIMARY CARE PHYSICIAN

Primary Care Physician

Address | City

Phone | Fax

EMPLOYMENT

Occupation

❑ Disabled ❑ Full time ❑ Not employed ❑ On active military duty ❑ Part time
❑ Retired ❑ Self employed ❑ Student - full time ❑ Student - part time ❑ Unknown

Employer | Employer Phone

Employer Address

INSURANCE

Do you have Medical Insurance: ❑ Yes ❑ No | Are you the insurance holder? ❑ Yes ❑ No

Group# | Subscriber#

Insurance Type: ❑ Personal/Family ❑ Workers' comp ❑ Third party ❑ Additional type

Who is responsible for this account? ❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other

Insured Name *(if different than patient)* | SS# | Birth Date

Address *(if different than patient)*

City | State | Zip | County

Home Phone ( ) | Work Phone ( ) | Mobile Phone ( )

Employer

Address

City | State | Zip | County

MEDICAL HISTORY Have you had any of the following? (Check all that apply)

Common Problems

- ❑ Atrial fibrilation
- ❑ Blood coagulation disorder
- ❑ Cancer
- ❑ Chronic kidney disease
- ❑ (CHF) Congestive heart failure
- ❑ Chronic obstructive pulmonary disease (COPD)
- ❑ Coronary artery disease
- ❑ Diabetes mellitus
- ❑ Gastroesophageal reflux disease (GERD)
- ❑ Glaucoma
- ❑ Heart valve disease
- ❑ Hepatitis C
- ❑ Hypertension
- ❑ Seizures
- ❑ Sleep apnea

Medical History

- ❑ Deep vein thrombosis
- ❑ History of radiation therapy
- ❑ Myocardial infarction
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Stroke
- ❑ Transient ischemia attack (TIA)
- ❑ Tuberculosis
- ❑ Ulcers (GI)

Anesthesia History

- ❑ Delayed emergence
- ❑ Difficult intubation
- ❑ Intraoperative awareness
- ❑ Malignant hyperthermia
- ❑ Motion sickness
- ❑ Post-operative nausea and vomiting (PONV)
- ❑ Pseudocholinesterase deficiency
- ❑ Sleep Apnea
- ❑ Spinal headache

SURGICAL HISTORY Have you had any of the following? (Check all that apply)

- ❑ AICD implants
- ❑ Amputation
- ❑ Anal/rectal surgery
- ❑ Aortic aneurysm repair
- ❑ Appendectomy
- ❑ AV fistula/graft
- ❑ Back surgery
- ❑ Bladder surgery
- ❑ Bowel surgery
- ❑ Breast biopsy
- ❑ CABG
- ❑ Carotid endarterectomy
- ❑ Cataract removal/IOL implant
- ❑ Cervical spine surgery
- ❑ Cholecystectomy
- ❑ Cosmetic surgery
- ❑ Craniotomy
- ❑ C-section
- ❑ Dental surgery
- ❑ Esophagus surgery
- ❑ Eye surgery
- ❑ Fracture surgery
- ❑ Heart valve surgery
- ❑ Hernia repair
- ❑ Hip surgery
- ❑ Implanted pump
- ❑ Indwelling vascular access
- ❑ Kidney transplant
- ❑ Knee surgery
- ❑ Lumbar laminectomy
- ❑ Lung surgery
- ❑ Lymph node biopsy
- ❑ Mastectomy
- ❑ Nephrectomy (kidney removal)
- ❑ Nephrostomy
- ❑ Orthopedic surgery
- ❑ Pacemaker
- ❑ Peripheral vascular access
- ❑ Prostate surgery
- ❑ Shoulder surgery
- ❑ Sinus surgery
- ❑ Spendectomy
- ❑ Stomach surgery
- ❑ Thyroid surgery
- ❑ Tonsillectomy
- ❑ Tracheostomy
- ❑ Tubal ligation
- ❑ TURP
- ❑ Vascualr surgery
- ❑ VP shunt
- ❑ Weight loss surgery

ENLOE

FAMILY HISTORY

FAMILY MEMBER	Living? (Y or N)	No known problems	Alcohol abuse	Anesthesia reaction	Anticoagulant use	Arthritis	Asthma	Birth defects	Blood transfusions	Cancer	COPD	Depression	Diabetes	Drug abuse	Early death	Hearing loss	Heart disease	Hyperlipidemia	Hypertension	Kidney disease	Learning disabilities	Mental illness	Mental retardation	Miscarriage	Stroke	Vision loss
Mother																										
Father																										
Sister																										
Brother																										
Maternal Grandmother																										
Maternal Grandfather																										
Paternal Grandmother																										
Paternal Grandfather																										

❑ Adopted ❑ Family history unknown

Comments:_____

SOCIAL HISTORY		
Tobacco use? ❑ YES ❑ NO	Start Date	Quit Date
	Type(s) used: ❑ Cigarettes ❑ Pipe ❑ Cigars	
	Packs per day_____ Years_____	
Smokeless tobacco use? ❑ YES ❑ NO	Start Date	Quit Date
	If yes, Type: ❑ Snuff ❑ Chew	
Alcohol Use? ❑ YES ❑ NO	Drinks per week: ( ) glasses of wine ( ) cans of beer ( ) shots of liquor ( ) standard drinks or equivalent	
Drug use? ❑ YES ❑ NO		

SOCIAL ASSESSMENT				
Do you live at home? ❑ YES ❑ NO				
Current living situation: ❑ Home ❑ Nursing home ❑ Assisted living ❑ Homeless				
Do you have a care partner who is willing to assist you with your needs? ❑ YES ❑ NO				
Do you have adequate transportation available for expected visits? ❑ YES ❑ NO				
Do you feel safe in your environment? ❑ YES ❑ NO				
Activity level: ❑ Very little activity ❑ Light exercise	❑ Daily activities ❑ Regular exercise	❑ Occasional exercise ❑ Extensive exercise		Number of days per week of exercise
Are you on a special diet? ❑ YES ❑ NO				

IMPLANTS	
Do you have any implants? ❑ YES ❑ NO If YES, ❑ Permanent ❑ Temporary	Type

HEALTH MAINTENANCE

Have you ever had?	Y	N	Year	Physician/Facility
Pap Smear				
Mammogram				
Colonoscopy				
HPV Vaccine				
Influezna (flu vaccine)				
DEXA scan (bone density)				

Have you ever had an abnormal pap smear? ❑ NO ❑ YES If Yes, When?_____

Have you ever had an abnormal mammography? ❑ NO ❑ YES If Yes, When?_____

Have you ever had an abnormal colonoscopy? ❑ NO ❑ YES If Yes, When?_____

GENERAL HEALTH HISTORY

ENLOE

Name_____ SS#_____

FALL RISK

Do you have problems with: ❑ Weakness ❑ Dizziness ❑ Assistive device ❑ Vision difficulty

Do you have a history of falling in the last 6 months? ❑ YES ❑ NO

Are you afraid of falling? ❑ YES ❑ NO

PLEASE LIST ALL KNOWN ALLERGIES – List drug type and reaction (ex. Penicillin ➡ rash, iodine or shellfish ➡ hives)

Drug/Food	Type of Reaction

LIST OF CURRENT MEDICATIONS – Including pain relievers, insulin, vitamins, herbs, birth control, over the counter medications etc.

Pharmacy of Choice:_____

Please list all pharmacies that fill your prescriptions on the lines below.

A:	D:
B:	E:
C:	F:

Medication Name	Dose taken	How often taken	Date started	Which pharmacy fills prescription? (enter A,B,C etc)

Current Medications

ENLOE
TOTAL JOINT REPLACEMENT PROGRAM

Name_____ Date of Birth_____

Please list all your current medications, dosages, and the reason you are taking them.
Thank you for assisting us in your care!

MEDICATION *Example: Aleve*	DOSAGE & FREQUENCY *Example: 220 Mg/ 2x a day*	MEDICAL CONDITION *Example: Knee pain*

Patient Information

Hip dysfunction and Osteoarthritis Outcome Score for Joint Replacement (HOOS, JR.), English version 1.0

HOOS, JR. HIP SURVEY

INSTRUCTIONS: This survey asks for your view about your hip. This information will help us keep track of how you feel about your hip and how well you are able to do your usual activities.
Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can.

Pain

What amount of hip pain have you experienced the **last week** during the following activities?

1. Going up or down stairs

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

2. Walking on an uneven surface

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Function, daily living

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

3. Rising from sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

4. Bending to floor/pick up an object

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

5. Lying in bed (turning over, maintaining hip position)

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

6. Sitting

None	Mild	Moderate	Severe	Extreme
☐	☐	☐	☐	☐

Patient Information

Outpatient Medical Information Release

ENLOE

Name_____ Date of Birth: _____/ _____/_____

RELEASE OF INFORMATION

I authorize the verbal release of information related to my outpatient visits at Enloe Medical Center.

This information may be released to:

- ❑ Spouse _____
- ❑ Child(ren) _____
- ❑ Other _____
- ❑ Information is not to be released to anyone other than me.

I request that the following information be excluded from this release of information and that it not be shared with those listed above.

- ❑ _____
- ❑ No Exclusions

MESSAGES

Please call me at (_____)_____-_____. If you are unable to reach me via phone:

- ❑ You may leave a detailed message
- ❑ Please leave a message asking me to return your call
- ❑ Do not leave a message

This release ***specifically excludes*** any psychiatry and psychology evaluations/records that are further restricted by HIPAA regulations.

I understand that it is my responsibility to update Enloe Medical Center with any changes to whom I authorize verbal release of my health information. This Release of Information will remain in effect for one year from the date below or until terminated by me in writing via an updated version of this form.

Patient Signature:_____ Date: _____/ _____/_____

Witness Signature:_____ Date: _____/ _____/_____

Patient Information