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Orthopedic Sports Medicine
Hip Arthroscopy & Preservation
Minimally Invasive Joint Replacement

NEW PATIENT GENERAL INTAKE FORM

Name: ____ **Age:** ________ **Date of Birth:** ___________________

Best Contact Number: ______________________________ **Email Address:** __________________________________

Primary Care Physician and Phone Number: ____

Preferred Pharmacy and Phone Number: ____

Who referred you to Dr. Nawas? ____

Goal for Today's Visit ____

Height: __________________ **Weight:** _______________

Where is your pain? _____________________________ Which side? ☐ Right ☐ Left ☐ Both

How long have you had pain? ____

Trauma/Injury: Was there an injury or event that started the pain? If so, explain:

____

Onset (Circle): Gradual OR Sudden **Timing (Circle):** Constant OR Intermittent

Pain: On a scale of 1-10, 10 being worst pain imaginable:

- What is your pain at rest? _________________________
- What is your pain with activity? ___________________

Describe: How would you describe your pain? (Aching, Dull, Burning, Throbbing, Sharp, Tight, Tingling)

Explain: ____

Mechanical Issues: Do you have any of the following symptoms? (Locking, clicking, or catching)

Explain: ____

Associated symptoms: ☐ Stiffness ☐ Swelling ☐ Decreased Mobility ☐ Dislocation

Do you have pain at night? YES OR NO **Does this pain wake you at night?** YES OR NO

Exacerbation: What makes your pain worse? ☐ Nothing ☐ Activity ☐ Lifting ☐ Twisting

☐ Sports ☐ Other: _________________________________

Alleviation: What makes your pain better? ☐ Nothing ☐ Rest ☐ Heat ☐ Ice ☐ Massage

☐ NSAIDS (Ibuprofen, Aleve) ☐ Tylenol ☐ Topical creams ☐ Other: ______________________________

Previous Treatments: Have you tried any of the following?

- ☐ NSAIDS (Aleve, Ibuprofen, Mobic, meloxicam) For how long? ________________________________
- ☐ Opioids (Hydrocodone, Percocet) For how long? ________________________________
- ☐ Steroid Injections How many? ________________________________
- ☐ Physical Therapy or Home Exercise Program For how long? ________________________________
- ☐ Joint support (Brace, Cane, Crutches, Walker, Scooter) Explain: ________________________________
- ☐ Tylenol ☐ Muscle Relaxant ☐ Glucosamine ☐ Pain Management ☐ Chiropractor
- ☐ Other Explain: ________________________________

Neurological Complaints: Do you have any of the following?

☐ Numbness ☐ Tingling ☐ Weakness ☐ Leg Pain ☐ None

Previous Imaging for this problem: ________________________________

Past Medical History: Have you had any of the following? **(Circle all that apply)**

Anemia	Emphysema (COPD)	Osteoporosis
Arthritis (Rheumatoid)	GERD / Reflux	Seizure / Epilepsy
Arthritis (Osteoarthritis)	Gout	Stomach ulcer
Asthma	Heart disease	Stroke
Blood clots	Hepatitis	Thyroid (high or low)
Cancer _______________	High blood pressure	_______________________
Depression	High cholesterol	_______________________
Diabetes	Kidney disease	_______________________

Past Surgical History (Including surgeries and year) ________________________________

____

Allergies and Reaction:

____

List All Current Medications With Dosage:

____

____

____

Nicotine use? Yes OR No Frequency _______________ **Alcohol use:** Yes OR No Frequency ______________

Occupation: ________________________________ **Work Related Injury (Circle):** YES OR NO

Are you a student? Where? ________________________________ **Sports?** ________________________________

Coach/Athletic Trainer Name: ________________________________

Physical/Recreational Hobbies: ________________________________

Name: ____________________________ Date of Birth: ____________________

Review of Systems Checklist

Are you currently Experiencing any of the following? (Check all that apply, please)

- [ ] Fever
- [ ] Chills
- [ ] Sweats
- [ ] Fatigue
- [ ] Weight loss
- [ ] Weight gain

- [ ] Blurry vision
- [ ] Decreased vision
- [ ] Loss of vision
- [ ] Eye pain
- [ ] Double vision
- [ ] Sensitivity to light
- [ ] Discharge from eyes

- [ ] Sore throat
- [ ] Nasal congestion
- [ ] Nasal discharge
- [ ] Black or bloody stool
- [ ] Nose bleeds
- [ ] Ringing in ear
- [ ] Hearing loss

- [ ] Chest pain
- [ ] Shortness of breath with activity
- [ ] Shortness of breath at rest
- [ ] Loss of consciousness
- [ ] Severe shortness of breath and coughing at night
- [ ] Swelling in the arms or legs
- [ ] Abnormal heartbeat

- [ ] Cough
- [ ] Coughing up blood
- [ ] Shortness of Breath
- [ ] Chest pain with breathing/coughing
- [ ] Wheezing

- [ ] Swollen lymph nodes
- [ ] Bleeding
- [ ] Bruising

- [ ] Abdominal pian
- [ ] Back pain
- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation

- [ ] Dizziness or vertigo
- [ ] Headache
- [ ] Weakness
- [ ] Numbness or tingling
- [ ] Problems with your speech
- [ ] Confusion
- [ ] Memory loss

- [ ] Rash
- [ ] Itching
- [ ] Hives