ORTHOMO
11330 Olive Blvd, unit 150
Creve Coeur, Mo 63141
Office line: (314) 782-1994

Husam Nawas, M.D
Orthopedic Sports Medicine
Hip Arthroscopy & Preservation
Minimally Invasive Joint Replacement

NEW PATIENT HIP 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:** _____

Which Hip? ☐ Right ☐ Left ☐ Both

How long have you had hip 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? _____

Location: Where is your hip pain located? (Groin Area, Buttocks, Outside, Diffuse)

Explain: _____

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

Explain: _____

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

Explain: _____

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

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

Exacerbation: What makes your pain worse? ☐ Nothing ☐ Activity ☐ Standing ☐ Walking ☐ Stairs

☐ Putting on shoes/socks ☐ Getting in or out of car/chair ☐ Running ☐ Sports Other: _____

Alleviation: What makes your hip 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 on your hip: _____

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 hip surgeries and year) _____

_____

Allergies: _____

List All Current Medications:

_____

_____

_____

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: _____