HOUSTON Methodist ORTHOPEDICS & SPORTS MEDICINE

Intake Form for follow-up patients

(Does not need to be completed by immediate post-operative patients)

Last Name:	First Name:	Age/Birthdate:
Best Contact Number:	Alternate Phone Number:	

Most Recent Description of Injury/Symptoms: (Please circle or print)

1. **Location** of the injury/problem: **Right / Left / Bilateral** (Arm, Shoulder, Elbow, Forearm, Wrist, Hand, Thumb, Index Finger, Middle Finger, Ring Finger, Small Finger_____
2. **What** is your symptom: pain/injury/numbness/deformity/loss of mobility/weakness/other:_____
3. **Date** of injury or when symptoms began:_____
4. If relevant, provide **date of surgery** and **type:**_____
5. **Recent severity** of your pain/symptoms: none mild moderate severe
6. Are your symptoms: improving/worsening/same?
7. **Recent description** of symptoms: sharp/dull/aching/throbbing/shooting/burning/constant/intermittent/ other:_____
8. **Recent Associated symptoms**: swelling, bruising, numbness, tingling, stiffness, snapping, deformity, weakness, open wounds, redness other:_____
9. **What has improved** the symptoms: rest/therapy/brace/injection/medication/surgery, other:_____
10. **Recent test(s)** and date: x-rays, nerve test, MRI, CT, other:_____

Have you experienced any of the following recently? Circle all that apply.

Fever, chills, fatigue, sleep problems, blurry vision, double vision, decreased hearing, sore throat, ears ringing, chest pain, fainting, shortness of breath, cough, heartburn, nausea, vomiting, constipation, diarrhea, rectal bleeding, pain with urination, incontinence, increased frequency, joint swelling, cramps, weakness, rash, itching, numbness, tingling, loss of balance, seizures, anxiety, depression, weight change, continuous thirst, rash, hay fever, easy bruising, easy bleeding, swelling, enlarged lymph nodes

Any **recent concerns/issues** you would like to discuss today:

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Patient Signature:_____ Date:_____ Physician / PA signature:_____