VOS valley orthopaedic specialists
orthopaedic surgery | sports medicine | onsite x-ray | physical therapy

Main Office:
2 Trap Falls Rd Ste 404
Shelton, CT 06484
Phone: (203) 734-7900
Fax: (203) 513-3269

Oxford Office:
144 Oxford Rd
Oxford, CT 06478
Phone: (203) 734-7900
Fax: (203) 463-8957

Fairfield Office:
1275 Post Rd, Ste 208
Fairfield, CT 06824
Phone: (203) 955-1202
Fax: (203) 955-1203
www.vosct.com

Medical Intake Form

Patient Name: _____ **Date of Appointment:** _____

Patient Date of Birth: _____ **Height:** _____ **Weight:** _____**lbs**

Sex: ☐ **Male** ☐ **Female** ☐ **Other:** _____

Preferred pharmacy: _____ **Primary Care Physician:** _____

- **Reason for Visit**

What brings you to the office today? (Please list **body part** and Right, Left, or Bilateral if applicable)

_____

_____

- **When did this problem begin?**

_____

- **What event or incident is this problem related to?**

☐ Work Accident ☐ Car Accident

☐ Other (Please specify): _____

Do you have an Attorney for this injury? ☐ Yes ☐ No

Attorney Name: _____

- **If this injury is related to a motor vehicle accident, please fill out this box:**

Type of Impact:
☐ Front ☐ Rear ☐ Driver's Side ☐ Passenger's Side

Were you wearing a seatbelt? ☐ Yes ☐ No

Did the airbags deploy? ☐ Yes ☐ No

- **Previous Studies** ☐ No Previous Studies

Please check any previous studies you have had for your current problem:

☐ Diagnostic X-rays ☐ MRI
☐ CT Scan ☐ Myelogram
☐ Discogram ☐ EMG/NCS
☐ Arthrogram ☐ Other _____

If you checked any of the boxes above please specify which facility you went to: _____ Date: _____

- **Previous Treatments**

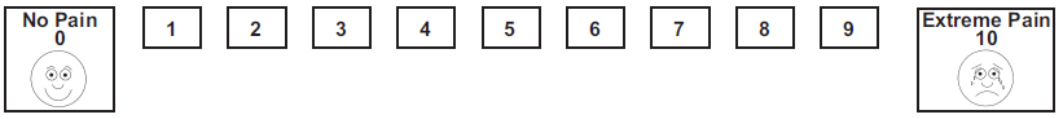
☐ Bracing ☐ Physical Therapy
☐ Chiropractic ☐ Massage
☐ Injections ☐ Ice/Heat
☐ Pain Medications/NSAIDs ☐ No Previous Treatments

- **Check the symptoms that best describe your problem:**

☐ Aching ☐ Throbbing ☐ Stabbing ☐ Burning
☐ Numbness ☐ Tingling ☐ Stiffness ☐ Swelling
☐ Pain ☐ Instability ☐ Other: _____

- **Are you right or left hand dominant?** ☐ Right ☐ Left

- **Pain Scale -** If you are having pain, please rate the intensity of your pain on a scale of 1-10.



Doctor's Notes - Office Use Only

- **Review of Systems/Medical History**

Are you currently having or have you ever had problems with any of the following?

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Ear/Nose/Throat
- ☐ Digestion
- ☐ Diabetes
- ☐ Balance Issues
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Pacemaker
- ☐ Gout/ Pseudogout
- ☐ Lyme Disease
- ☐ MRSA
- ☐ Lungs/Breathing
- ☐ Bowel Movement
- ☐ High Blood Pressure
- ☐ Blackout/Fainting
- ☐ Anesthesia
- ☐ Epilepsy
- ☐ Cardiac Stent
- ☐ Blood Clots
- ☐ DVT
- ☐ Heart Disease
- ☐ Problems
- ☐ Bladder Problems
- ☐ Bleeding Disorder
- ☐ Psychological Problems
- ☐ Stroke
- ☐ Polio

If you checked **any** of the boxes in the above sections, please describe in detail:

_____

_____

_____

- **Family Medical History**

Has any of your immediate family members suffered any of the following conditions? If so, please check boxes accordingly.

Condition	Father	Mother	Brother	Sister
Cancer	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Hypertension (HT)	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐

☐ Family History Unknown ☐ No Known Family History

If you checked any of the boxes under **Cancer**, please specify which type of cancer: _____

- **Allergies** ☐ No Known Allergies

Are you allergic to any of the following?

☐ Penicillin ☐ Latex ☐ Codeine

☐ Sulfa ☐ Shellfish ☐ Adhesive Tape

☐ Iodine/IV Dye ☐ Aspirin ☐ Local Anesthetics

☐ Eggs/Avian Products ☐ Other: _____

List reaction: _____

- **Social & Lifestyle Factors**

Have you ever smoked?	Yes ☐ No ☐	# Of Years? _____	# Per Day? _____	Current Smoker? Yes ☐ No ☐
Do you use recreational drugs?	Yes ☐ No ☐	What Types / How Often? _____		
How many alcoholic beverages do you consume per week? _____		How many times a week do you exercise? _____		

- **Hospitalizations & Surgeries**

Have you had any previous surgeries? Yes ☐ No ☐

If yes, did you have any complications with your previous surgery/anesthesia? Yes ☐ No ☐

Please list below any surgeries and/or procedures you have had in the past:

Procedure:	Date:
Procedure:	Date:
Procedure:	Date:

- **Medications/Supplements** (Please list all current medications/supplements below):

Are you currently taking any blood thinners? Yes ☐ No ☐

Medication	Strength	Times per day

Medication	Strength	Times per day

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____