

The Orthopaedic Center\ Yogesh Mittal, M.D.

New Patient Intake Form

Primary Care Physician: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Date of injury or date problem began: \_\_\_/\_\_\_/\_\_\_ (give approximate date if unknown)

Please describe: \_\_\_\_\_  
\_\_\_\_\_

Previous Treatment: (Circle all that apply)

XRAY MRI THERAPY INJECTION – TYPE: \_\_\_\_\_ OTHER: \_\_\_\_\_

Medical Conditions: (Circle all that apply)

Diabetes COPD Heart Disease High Cholesterol Thyroid (Hi/Lo) Hypertension

Asthma Anemia Stroke Kidney Disease Liver Disease Anxiety Depression

Cancer – Type: \_\_\_\_\_ Other: \_\_\_\_\_

Past Surgical History:

\_\_\_\_\_  
\_\_\_\_\_

Family History:

\_\_\_\_\_

Tobacco: \_\_\_\_\_ ppd Alcohol: \_\_\_\_\_ Dominant Hand: R or L

Meds: \_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

Review of Systems: (Circle all that apply)

Fever Chills Nausea Vomiting Chest pain Shortness of Breath Headache

Abdominal Pain Constipation Diarrhea Urinary Problems Paralysis

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Occupation: \_\_\_\_\_