General Intake Survey
Brian J. Cole, MD, MBA

Last Name ___________________________ First Name _________________________ Today's Date ___/___/___

Date of Birth ____ /____ /_____ Male _____ Female _____ Height _____ft_____in Weight________

Occupation______________________________________ Email Address ____

What joint (s) are you being evaluated for today: Shoulder _____ Elbow_____ Knee _____ Other (list) _________

How did you hear about us?

- TV
- Internet
- News publication
- Friend/Family member
- Another Physician
- Other:

If you wish to have a letter sent to your referring source, please provide name and address:

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Is there a legal case with this injury? Yes_____ No______ Is this a work related injury? Yes_____ No______

If YES, date of work related injury _____ /_____ /_____

Past Medical History

Have you ever been treated for any of the following illnesses? Please check all that apply.

	High Blood Pressure		Diabetes
	Heart Disease/Heart Attack		Stroke
	Emphysema/Bronchitis		Hepatitis
	Depression/Anxiety		Immunodeficiency Diseases
	Bleeding Disorders		Bleeding Disorders
	Cancer		Arthritis
	Ulcers		Neurologic Disorders

Please list any additional illnesses/conditions not listed above:

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Do you have a family history of any medical problems? Yes_____ No ______

If YES, please list family history below:

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Please list any current medications, including over–the-counter medications

1. ___________________________________
2. ___________________________________
3. ___________________________________
4. ___________________________________
5. ___________________________________

Do you have any allergies to medication? Yes_____ No _____

1. If YES, please list medication allergies
    a. _________________________________
    b. _________________________________
    c. _________________________________
    d. _________________________________
    e. _________________________________

Tobacco Use: Yes_____ No____ Packs per day_____ Alcohol Use (approx # of drinks per week): _________________

Past Surgical History

1. Have you ever undergone surgical intervention? Yes_____ No______
    a. If YES, have you ever had any problems with general anesthesia? Yes______ No ______

2. Please list all past surgeries to your affected joint **if being seen for a joint other than the shoulder, elbow or knee**:
    a. Surgery ____ Date________________________
    b. Surgery ____ Date ________________________
    c. Surgery ____ Date ________________________
    d. Surgery ____ Date ________________________
    e. Surgery ____ Date ________________________