



The Lyman Knee Clinic

Jeffrey R. Lyman, MD

Patient Intake Form

Today's Date: _____

Name: _____ Birth Date: _____

Guarantor Info if under 18: _____

SS #: _____ Age: _____ Gender: M / F Email: _____

Address: _____

Phone: _____
(home) (work) (cell)

Marital Status: Single Married Divorced/Separated Widowed

Preferred Language: English Other: _____

Race: American Indian Asian Black/African American Japanese White Other: _____ Declined

Ethnicity: Central American Hispanic or Latino/Spanish Not Hispanic or Latino Other: _____ Declined

Employer/address: _____

Primary Insurance Coverage:

_____ (Name of Carrier)	_____ (Policy Number)	_____ (Group Number)
_____ (Subscribers Name & Relationship to patient)	_____ (Subscriber DOB)	_____ (Insurance Phone)

Secondary Insurance Coverage:

_____ (Name of Carrier)	_____ (Policy Number)	_____ (Group Number)
_____ (Subscribers Name & Relationship to patient)	_____ (Subscriber DOB)	_____ (Insurance Phone)

1) How did you hear about us or who sent you to see us?

Name _____ Phone _____

2) Who is your Primary Care Physician?

Name _____ Phone _____

City, State, Zip _____

What Pharmacy do you use?

Name _____ Phone _____

City, State & Zip _____

Are you currently taking any narcotics? Yes No What? _____ How long? _____

I agree that The Lyman Knee Clinic may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature of Patient or Patient's Representative: _____

3) Chief Complaint/Current Illness:

- a) Is your problem in the: Right Knee Left Knee
- b) Describe your chief complaint? _____

- c) How long have you had this problem? _____
- d) Is your problem getting: Worse Better Staying the same
- e) Was this a result of an injury? Yes No If Yes, what was the Date of Injury? _____
If yes, please describe how it happened: _____

4) Please list all medications you currently use with dosage and frequency:

5) Do you have any allergies? Yes No

If yes, please list _____

6) Are you currently or have you ever had problems with the following:

	YES	NO	Describe all "YES" responses
Heart Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breathing, Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis, AIDS, TB	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowels or colon	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Balance problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blackout or fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____

7) Please list all past surgeries and hospitalizations:

Surgery/Hospitalization	Date	Physician

8) Have you ever had problems with general anesthesia? YES NO

9) Do you drink alcohol? YES NO If yes, how much per week? _____

10) Do you smoke? YES NO If yes, how much per week? _____
If yes, how long have you smoked? _____

11) Do you:

	YES	NO	
Have children	<input type="checkbox"/>	<input type="checkbox"/>	How many _____
Live alone	<input type="checkbox"/>	<input type="checkbox"/>	If no, with whom _____
Use a special diet	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____
Use recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____
Exercise regularly	<input type="checkbox"/>	<input type="checkbox"/>	How often _____

12) Sports/Hobbies: _____

13) Family History

Member	If Alive, Age & Health Status	If Deceased, Age at Time of Death & Cause
Father	_____	_____
Mother	_____	_____
Sibling 1	_____	_____
Sibling 2	_____	_____
Sibling 3	_____	_____

14) Work-Related Injury:

- a) Job title: _____
- b) How long have you worked for this employer? _____
- c) Date of injury: _____
- d) Are you: off work modified duty full duty
- e) If you are not working full duty, what date did you last do so: _____

16) If PAIN is one of your complaints, please complete the following questions.

- a) Front Back Inside surface of knee Outside surface of knee Behind kneecap
- b) Rate the average intensity of your pain/discomfort. (0=no pain, 10=severe pain)
0 1 2 3 4 5 6 7 8 9 10
- c) Describe your Pain: Intermittent Constant
 Dull Sharp Throbbing
 Tight Burning Tingling

17) Timing

- 1) Is your pain worse at any particular time of the day? Morning Evening Night
- 2) Does your knee allow you to sleep comfortably? Yes No

18) Activity-Related Symptoms:

- 1) Is your knee comfortable at rest? Yes No
- 2) Can you walk without using supports (brace, crutches, cane, etc.)? Yes No
- 3) Can you walk without a limp? Yes No
- 4) Can you walk without your knee locking or catching? Yes No
- 5) Can you walk up one flight of stairs? Yes No
- 6) Can you walk up five flights of stairs? Yes No
- 7) Can you run the length of one block? Yes No
- 8) Can you run one mile? Yes No
- 9) Does your knee allow you to pivot, change directions, or jump without "giving way"? Yes No
- 10) Does your knee allow you to perform your normal activities of daily living (other than work or sport)? Yes No
- 11) Does your knee allow you to participate in sports? Yes No
- 12) Can you participate in sports at the level of competition you desire? Yes No
- 13) Does your knee allow you to work full-time at your job? Yes No

19) Do you ever have any of these additional symptoms?

	YES	NO	If yes, describe
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Instability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Painful	<input type="checkbox"/>	<input type="checkbox"/>	_____
Roughness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

20) Have you tried any of the below? Relief of Symptoms?

	YES	NO	
Medication	<input type="checkbox"/>	<input type="checkbox"/>	Type:_____
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how long did you attend?_____
			When was your last session?_____
Injections	<input type="checkbox"/>	<input type="checkbox"/>	If yes, location & medication?_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	Describe:_____

_____ I acknowledge that I have received the Notice of Privacy Practices of Lyman Orthopedics (tri-fold pamphlet), which explains its legal duties and privacy practices with respect to my protected health information.

By signing below, I agree that all the information provided is true to the best of my knowledge. I also hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for the noncovered services. I also authorize the physician to release any information required to process this claim.

Patient Signature _____ **Date** _____

I have reviewed the above information in detail with the patient.

Physician Signature _____ **Date** _____

Jeffrey R. Lyman, MD