The Lyman Knee Clinic
Jeffrey R. Lyman, MD

Patient Intake Form

Today's Date: _____

Name: _____ **Birth Date:** _____

Spouse: _____ **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 Name & 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) Please list all medications you currently use with dosage and frequency:

_____

_____

4) Do you have any allergies to any medications? ☐Yes ☐No
If yes, please list and give your reaction you get to the medication:

_____

5) Are you allergic to Latex or Tape? ☐Yes ☐No

6) Have you ever had MRSA? ☐Yes ☐No

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

	Y	N		Y	N
No Past Medical Problems Reported			Liver Disease		
Anxiety Disorder			Low Back Pain		
Arthritis: What Kind:_____			Neck Pain		
Asthma			Mid Back Pain		
Bleeding Disorder			Radiculopathy – Upper		
Blood Clots (Deep Vein Thrombosis)			Radiculopathy – Lower		
Cancer: What Kind:_____			Organ Transplant		
CHF			Osteopenia		
Claustrophobic			Osteoporosis		
Coronary Artery Disease			Other Lung Disease		
COPD			Poliomyelitis		
Diabetes Type I			Peripheral Vascular Problem		
Diabetes Type II			Pulmonary Embolism		
Dialysis			Reflux Disease		
Diverticulitis			Rheumatoid Arthritis		
Fibromyalgia			Sciatica		
Gout			Stroke		
Pacemaker			Tuberculosis (TB)		
Heart Arrhythmia			Ulcers		
Heart Attach (MI)			Urinary Tract Infection		
Heart Murmur			Other:		
Hiatal Hernia			Problems with Anesthesia		
HIV or AIDS			Hepatitis		
Hypertension					
Hypercholesterolemia					
Hyperthyroidism					
IBS (Irritable Bowel Syndrome)					
Kidney Disease					
Kidney Stones					
Leg/Foot Ulcers					

8) Please list all past surgeries and hospitalizations:

Surgery/Hospitalization	Date	Physician

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

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

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

12) Do you:

	YES	NO	
Have children	☐	☐	How many_____
Live alone	☐	☐	If no, with whom_____
Use a special diet	☐	☐	Describe_____
Use recreational drugs	☐	☐	Describe_____
Exercise regularly	☐	☐	How often_____
Sports/Hobbies	☐	☐	What_____

13) Family History

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

14) Current Vitals:

Height: _____ Weight:_____

15) 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: _____

_____

16) 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: _____

17) 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

18) 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

19) 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

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

	YES	NO	If yes, describe
Stiffness	☐	☐	_____
Numbness	☐	☐	_____
Swelling	☐	☐	_____
Instability	☐	☐	_____
Weakness	☐	☐	_____
Painful	☐	☐	_____
Roughness	☐	☐	_____
Other	☐	☐	_____

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

	YES	NO	
Medication	☐	☐	Type: _____
Physical Therapy	☐	☐	If yes, how long did you attend? _____
			When was your last session? _____
Injections	☐	☐	If yes, location & medication? _____
Other	☐	☐	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