The Orthopaedic Center of Corpus Christi

Patient Intake Form

(Please answer all questions)

Name: _____ Age: _____ Today's Date: _____

Address: _____

Telephone Number: _____

Primary Physician: _____ ***Referring Physician:*** _____

What brings you to see us today? What happened? What hurts?

_____

_____

Have you had any X-rays or MRI for ***this*** problem? ***Yes*** ***No***

If yes, ***where*** were they performed and ***when*** ? _____

Which side is affected? ***Right*** ***Left*** ***Both*** ***Right handed or Left handed*** (*circle one*)

Date of injury or onset of problem? _____ Height: _____ Weight _____

Is this injury work related? ***Yes*** ***No*** If yes, did you file a claim with your employer? ***Yes*** ***No***

Is there a lawsuit or attorney involved? ***Yes*** ***No***

Employer: _____ Occupation: _____

Have you ever had surgery? ***Yes*** ***No*** ***If so, please list below:***

_____

_____

_____

What medications do you currently take?

_____

_____

_____

Have you ever had an allergic reaction to medication? ***Yes*** ***No*** ***If so, please list below:***

_____

_____

_____

_____ _____

Signature **Date**