

NEW PATIENT INTAKE FORM

Dr. Sai Tummala · Stanford Orthopaedics and Sports Medicine


Stanford
MEDICINE

Please complete this form as thoroughly as possible. Circle YES or NO for each item where indicated.

PATIENT & VISIT INFORMATION

Patient Name (Last, First) _____

Weight (lbs) _____ Height (ft, in) _____

Age _____ Date of Birth _____

Primary Care Physician _____

Reason for Visit _____

How did you hear about us? _____

Primary sport / position _____ Level: ☐ Recreational ☐ High school ☐ College ☐ Professional

Please list the goals for your visit today

For example: improved function, decreased pain, or getting back to running or a specific activity.

How much improvement do you expect from treatment? _____ % (0 = none, 100 = complete resolution)

ABOUT YOUR CURRENT PROBLEM

Please answer the questions below about the problem bringing you in today. This helps Dr. Tummala understand your symptoms in detail.

Which body part or joint is bothering you? _____ Side: ☐ RIGHT ☐ LEFT ☐ BOTH

Dominant hand: ☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS Related to a work injury, car accident or legal claim? YES NO

ONSET - When did the problem first start? Was there a specific injury or event?

WHAT MAKES IT BETTER? (rest, ice, medication, activity change, therapy)

DURATION - How long have you had these symptoms?

WHAT MAKES IT WORSE? (specific activities, positions, movements)

TIMING - Constant or comes and goes? Any time of day worse (night pain)?

What sports, activities, or work are you trying to get back to?

CHARACTER - How would you describe the symptoms? Check all that apply:

- ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Stabbing ☐ Shooting ☐ Cramping
- ☐ Stiffness ☐ Weakness ☐ Numbness ☐ Tingling ☐ Catching / locking ☐ Giving way / instability ☐ Grinding

Pain Severity

On a scale of 0 to 10, where 0 = no pain and 10 = pain so severe you cannot use the extremity at all:

Pain on an AVERAGE day (baseline):

0 1 2 3 4 5 6 7 8 9 10

Pain AT ITS WORST:

0 1 2 3 4 5 6 7 8 9 10

SANE

If a completely normal, healthy extremity is 100%, how would you rate your affected extremity today? _____ % (0 = non-functional, 100 = normal)

Treatments You Have Already Tried**Prior Care & Imaging**

Prior Evaluation	Circle one
Have you previously seen another doctor or provider for this problem?	YES NO
Have you had any imaging for this problem? (X-ray, MRI, CT, ultrasound)	YES NO
Have you had prior surgery on this same body part or for this problem?	YES NO

If you have had imaging, please list the type, approximate date, and where it was done. Bringing a copy or disc to your visit is very helpful.

Imaging type: _____ Date: _____ Where performed: _____

Imaging type: _____ Date: _____ Where performed: _____

If you have seen another provider or had prior surgery for this problem, please explain (who, when, and what was done):

Physical Therapy

Physical Therapy	Circle one
Have you done formal physical therapy for this problem?	YES NO

If YES - Duration: _____ Approx. # of sessions: _____

Relief: _____ %

Are you still doing the exercises? Anything that helped or worsened your symptoms?

Medications for Pain

Pain Medication	Circle one
Are you taking any medication for this pain? (ibuprofen, naproxen, acetaminophen/Tylenol, etc.)	YES NO

If YES - Medication: _____ How often: _____

Relief: _____ %

Medication: _____ How often: _____

Relief: _____ %

Injections

Injections	Circle one
Have you had any injections for this problem?	YES NO

If YES - what type (cortisone/steroid, gel/hyaluronic acid, PRP, other), when, and what percentage of relief did you get?

Type of injection: _____ Date: _____ Relief: _____ %

Type of injection: _____ Date: _____ Relief: _____ %

Other treatments tried (bracing, chiropractic, acupuncture, activity modification, prior surgery for this problem, etc.):

Anything else about this problem we should know?

♥ PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the conditions below? Circle YES or NO for each.

CARDIOVASCULAR / HEART DISEASE			
Hypertension (high blood pressure)	YES NO	Irregular heartbeat (arrhythmia)	YES NO
Coronary artery disease / stent / bypass	YES NO	Myocardial infarction (heart attack)	YES NO
Cardiomyopathy or CHF	YES NO	Aortic aneurysm / dissection	YES NO
Heart valve disease	YES NO	Pulmonary hypertension	YES NO
ENDOCRINE			
Diabetes	YES NO	Hypothyroidism	YES NO
GASTROINTESTINAL / LIVER			
Chronic liver disease	YES NO	Liver failure	YES NO
Stomach ulcers	YES NO	Hepatitis	YES NO
HEMATOLOGIC / BLOOD CLOTTING			
Blood clot (DVT or PE)	YES NO	Known clotting disorder (Factor V, etc.)	YES NO
FAMILY history of blood clots	YES NO	Bleeding / bruising / blood disorder	YES NO
Coagulation defect	YES NO	Anemia	YES NO
Peripheral vascular disease	YES NO	Thrombocytopenia / platelet defects	YES NO
Heparin reaction	YES NO		
NEUROLOGICAL			
Stroke (CVA) with deficit	YES NO	Transient ischemic attack (TIA)	YES NO
Epilepsy / seizures	YES NO	Polyneuropathy	YES NO
PSYCHOSOCIAL			
Alcohol abuse / dependency	YES NO	Anxiety	YES NO
Depression	YES NO	Drug abuse / dependency	YES NO
RESPIRATORY			
Asthma / bronchitis / emphysema	YES NO	COPD	YES NO
Obstructive sleep apnea	YES NO	Other pulmonary conditions	YES NO
OTHER			
History of cancer	YES NO	Chronic kidney disease	YES NO
Immune disorder	YES NO	Vitamin D deficiency	YES NO
Malnutrition	YES NO		

If you circled YES to any condition above, please explain, and list any other conditions not shown:

MEDICAL & SOCIAL HISTORY

Surgical History

List any prior surgeries, with year and surgeon/hospital if known.

Surgery / Procedure	Year
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Anesthesia	Circle one
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Have you or a family member ever had a problem with anesthesia? **YES NO**

If YES, please explain (e.g., difficulty waking up, severe nausea, breathing problems, family history of malignant hyperthermia):

Allergies

Allergy	Circle one
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Penicillin **YES NO**

Any other medications **YES NO**

Latex **YES NO**

If YES, list each allergy and your reaction. Include any others not listed:

Current Medications

Include prescription, over-the-counter, vitamins, and supplements.

Medication	Dose / Frequency
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Blood Thinners

Anticoagulation	Circle one
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Taking any blood thinner? (Coumadin, Eliquis, Xarelto, Plavix, aspirin, etc.) **YES NO**

If YES - Medication: _____ Dose: _____

Why are you taking it? (afib, prior clot, stent, heart valve):

Social History

Question	Circle one
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Tobacco or nicotine in ANY form? (cigarettes, vaping, chew, pouches) **YES NO**

Marijuana or cannabis in any form? **YES NO**

Alcohol? **YES NO**

Opioids? **YES NO**

Any drugs other than prescribed or OTC? **YES NO**

Tobacco/nicotine - form, amount, years:

Alcohol - amount per week:

If YES to marijuana, opioids, or other drugs - what, how much, how often:

Current occupation:

HOW YOU HANDLE SETBACKS

Please indicate how much you agree with each statement.

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I tend to bounce back quickly after hard times	1	2	3	4	5
I have a hard time making it through stressful events	5	4	3	2	1
It does not take me long to recover from a stressful event	1	2	3	4	5
It is hard for me to snap back when something bad happens	5	4	3	2	1
I usually come through difficult times with little trouble	1	2	3	4	5
I tend to take a long time to get over setbacks in my life	5	4	3	2	1
Total Score _____ / 30					