

*(Online Downloaded Forms)*

**Patient Intake Form**

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 Orthopaedic Surgeon

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 Orthopaedic Surgeon

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 Physician Assistant

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 Physician Assistant

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 Physician Assistant

**Kayla Cook, PA-C**  
 Physician Assistant

**Laurie Machuca**  
 Director of Operations

**Which doctor/colleague referred you here?** \_\_\_\_\_

**Where is your pain?**

Right Hip     Right Knee     Back     Left Hip     Left Knee

**When did this pain begin?** # \_\_\_\_\_  years ago     months ago     weeks ago

**Rate your pain on a scale of 1-10** (1= minimal, 10 = worst possible) \_\_\_\_\_

**Is your pain:**             intermittent             constant

**Is your pain:**

getting worse, over the recent # \_\_\_\_\_ years / months / weeks (circle one)

staying the same             getting better

**Is your pain worse with:**

standing             standing for long periods             up stairs  
 walking             walking long distances             down stairs  
 twisting             getting out of bed             getting out of a chair  
 wakes you from sleep at night

**If you are having HIP PAIN, where is it located?**

groin             thigh             down below the knee  
 side of hip             down to the knee             down to the foot

**If you are having KNEE PAIN, where is it located?**

inside of the knee (close to other knee)     front of knee (near kneecap)  
 outside of knee (away from other knee)     back of knee

**How would you describe your pain?**

sharp     throbbing             burning     dull     tight     achy

**Do you have any of the following?**

stiffness     instability             swelling     weakness     numbness

**Do you have a limp?**

none             slight             moderate             severe

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**How far can you walk prior to experiencing pain?**

- unlimited       7-10 blocks       4-6 blocks       2-3 blocks  
 indoors only       bed to chair only       unable to walk

**Do you need assistance walking?**

- none       cane long distances       cane all times       walker       wheelchair

**Do you have difficulty with stairs?**

- none       one step at a time       use the banister       cannot do stairs

**Do you have difficulty putting on your shoes and socks?**

- none       with difficulty       unable

**Can you sit in a chair comfortably?**

- any chair for more than 1 hour       high chair for ½ hour  
 unable to sit for ½ hour

**Can you get up from a chair?**

- normally       must use arms       difficult even when using arms  
 require assistance

**Have you tried any of the following medications?**

- Tylenol       Aspirin       Celebrex       Motrin       Aleve       ibuprofen  
 other \_\_\_\_\_

**Have you tried injections?**

- no  
 yes-  
     steroids       synvisc/rooster comb/hyaluronic acid       unsure  
    how many injections? \_\_\_\_\_

**Have you tried any of the following?**

- knee bracing       knee compression sleeve       weight reduction  
 physical therapy       home exercises  
 chiropractor       acupuncture  
 other \_\_\_\_\_



**Do you currently have any conditions involving the following?**

**Constitutional:**

fevers/chills  yes  no  
 weight loss  yes  no

**Eyes:**

changes in vision  yes  no  
 glaucoma  yes  no

**Ears, mouth, throat:**

changes in hearing  yes  no  
 active dental problem  yes  no

**Cardiovascular:**

Palpitations  yes  no  
 chest pain  yes  no  
 heart murmur  yes  no

**Respiratory:**

shortness of breath  yes  no  
 sleep apnea  yes  no

**Gastrointestinal:**

nausea  yes  no  
 bowel/bladder change  yes  no  
 ulcer  yes  no  
 kidney problems  yes  no  
 liver problems  yes  no

**Endocrine:**

Diabetes  yes  no  
 Thyroid disease  yes  no

**Integumentary:**

new rashes or lesions  yes  no

**Neurological:**

New numb/weakness  yes  no  
 seizures/epilepsy  yes  no

**Psychiatric:**

Depression  yes  no  
 Schizophrenia  yes  no

**Hematologic:**

Blood clots  yes  no

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_