ORTHOPAEDIC INTAKE FORM

Patient Name: _____ **DOB:**_____

Preferred Pharmacy - Name/Address: _____

Preferred Laboratory – Name/Address: _____

Email Address: _____

CURRENT MEDICAL INFORMATON

What is the reason for your visit today? _____

Height:_____ **Weight:** _____

Pain Scale from 1 to 10 (10 being the worst?) _____

ALLERGIES

Please list any allergies you have and the adverse reaction.

	Allergic to:	**Physical Response:**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

MEDICATIONS

1.	_____	**5.**	_____
2.	_____	**6.**	_____
3.	_____	**7.**	_____
4.	_____	**8.**	_____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

Y or N	**Fever**	Y or N	**Night Sweats**
Y or N	**Eye Irritation**	Y or N	**Vision Changes**
Y or N	**Difficulty hearing**	Y or N	**Teeth Problems**
Y or N	**Mouth Breathing**		

Patient Name: _____ **DOB:**_____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

Y or N	**Chest Pain**	Y or N	**Shortness of breath when walking**
		Y or N	**Shortness of breath lying down**
Y or N	**Shortness of breath**	Y or N	**Wheezing**
Y or N	**Sleep Apnea**		
Y or N	**Abdominal Pain**		
Y or N	**Difficulty Urinating**	Y or N	**Increased Frequency**
Y or N	**Incomplete emptying**		
Y or N	**Muscle Aches**	Y or N	**Muscle Weakness**
Y or N	**Joint Pain**	Y or N	**Back Pain**
Y or N	**Swelling of the extremities**		
Y or N	**Skin rashes**	Y or N	**Growths or lesions**
Y or N	**Seizures**	Y or N	**Dizziness**
Y or N	**Headaches**	Y or N	**Migraines**
Y or N	**Depression**	Y or N	**Sleep disturbance**
Y or N	**Fatigue**	Y or N	**Increased thirst**
Y or N	**Easy bruising**	Y or N	**Excessive bleeding**
Y or N	**Hives**		

SOCIAL HISTORY

What is your smoking status? Currently Every Day, Currently Some days, Formerly Smoked, Never Smoked

How much do you smoke?

¼ pack per day?	¼ pack per week?
½ pack per day?	½ pack per week?
1 pack per day?	1 pack per week?
2 packs per day?	2 packs per day?
3 packs or more per day?	

Have smoked since what age? _____

What is your alcohol intake? Occasional Moderate Heavy

How many years of alcohol use? _____

Work related Injury? _____ **Auto Accident Injury?** _____

Do you take any illicit drugs? _____ **Are you employed?** _____

Patient Name: _____ **DOB:**_____

PAST MEDICAL HISTORY

Have you experienced any of the following symptoms in the PAST?

Y or N	**Arthritis**	Y or N	**Anemia, Bleeding Disorders/Tendencies**
Y or N	**Blood Clots**	Y or N	**Breathing problems**
Y or N	**Cancer**	Y or N	**Chest pain/heart attach/arrhythmia**
Y or N	**Coronary Artery Disease**	Y or N	**Depression/Psychiatric Problems**
Y or N	**Diabetes**	Y or N	**Excessive thirst/Fatigue**
Y or N	**Eye Problems**	Y or N	**Fever, chills, headaches**
Y or N	**Gout**	Y or N	**Hypertension/High Blood Pressure**
Y or N	**HIV/AIDS**	Y or N	**Heart Attack, Myocardial Infarction**
Y or N	**Heart Disease/Problems**	Y or N	**Hepatitis**
Y or N	**Hereditary Defects**	Y or N	**Kidney Disease**
Y or N	**Leg or foot ulcers**	Y or N	**Lung Disease**
Y or N	**Osteoporosis**	Y or N	**Pacemaker**
Y or N	**Rheumatoid Arthritis**	Y or N	**Sexually Transmitted Disease**
Y or N	**Skin rash/boils/problems**	Y or N	**Stomach problems/Reflux/GERD**
Y or N	**Stomach Ulcers**	Y or N	**Stroke**
Y or N	**Tuberculosis**	Y or N	**Tremors/Seizures/Dizziness/Epilepsy**
		Y or N	**Urinary Pain/Frequency/Retention**

FAMILY HISTORY OF MEDICAL PROBLEMS

Please list any past family history of specific medical problems/diseases.

Mother: _____ **Died:** _____

Father: _____ **Died:** _____

Sister: _____ **Died:** _____

Brother: _____ **Died:** _____

Additional:_____ **Died:** _____

Additional:_____ **Died:** _____

PAST SURGERY HISTORY

Please list all past surgery history within the last 10 years, beginning with most recent.

	Surgical Procedure	Date of Surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____