New Patient History & Intake Form

Patient Information

Patient Name: ______________________________ Date of Birth: ______________________________

Date of Visit (Today's Date): ____________________ Date of Injury (if applicable): ___________________

Right or Left Handed: _________________________ Referring Provider: __________________________

Preferred Pharmacy Name/Address: ______________________________ Occupation: ___________________

Race: __________________ Ethnicity: ________________ Preferred Language: ______________

Past Medical History (please check all that apply):

Anemia, Chronic
Anxiety
Asthma
Irregular Heartbeat
Bipolar Disorder
Breast Cancer
Hyperlipidemia
Ischemic Heart Disease
Chronic Pain
Colon Cancer
COPD
Coronary Artery Disease
Deep Vein Thrombosis
Depression
Diabetes, Insulin Dependent
Diabetes, Non Insulin
End Stage Renal Disease
GERD
Hepatitis
HIV/AIDS
High Cholesterol
Hyperparathyroidism
Hypertension
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Multiple Myeloma
Obesity, Morbid
Obesity
PBPH
Prostate Cancer
Pulmonary Embolism
Radiation Therapy
Fibromyalgia
Rheumatoid Arthritis
Sleep Apnea
Seizures
Stroke
NONE
Other__________________

Past Surgical History (please check all that apply):

Appendix (Appendectomy)
Breast: Mastectomy
○Right ○Left ○Both
Breast: Lumpectomy
○Right ○Left ○Both
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colon: Colostomy
Gallbladder Removal
Heart: Biological Valve Replacement
Heart: Coronary Artery Bypass Surgery
Heart Transplant
Heart: Mechanical Valve Replacement
Heart: PTCA
Kidney Stone Removal
Kidney Transplant
Liver: Hepatectomy
Liver: Liver Transplant
Liver: Shunt
Ovaries Removed: Ovarian Cancer
Ovaries: Tubal Ligation
Pancreas: Pancreatectomy
Prostate Removed: Prostate Cancer
Prostate Removed: TURP
Rectum: APR
Rectum: Low Anterior Resection
Skin: Basal Cell Carcinoma
Skin: Melanoma
Skin: Skin Biopsy
Skin: Squamous Cell Carcinoma
Hysterectomy
Hysterectomy: Caesarean
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer
NONE
Other__________________

Past Orthopedic History (please check all that apply):

Ankle Fracture
Ankylosing Spondylitis
Bursitis
DISH
Epidural Injections, Spine
Fracture
Gout
Hip Fracture
HNP, Cervical
HNP, Lumbar
Metastatic Bone Disease
Osteoarthritis
Osteopenia
Osteoporosis
Primary Bone Sarcoma
Psoriatic Arthritis
Rheumatoid Arthritis
Ricketts
RSD
Sciatica
Scoliosis
Spine Fracture
Soft Tissue Sarcoma
Spinal Stenosis, Cervical
Spinal Stenosis, Lumbar
Vertebral Body
Compression Fracture
Vitamin D Deficiency
Wrist Fracture
NONE
Other___________________

Past Orthopedic Surgery (please check all that apply):

Achilles Tendon Repair
○Right ○Left ○Both
ACL Reconstruction
○Right ○Left ○Both
Ankle Fracture ORIF
○Right ○Left ○Both
Bunion Correction
○Right ○Left ○Both
Carpal Tunnel Decompression
○Right ○Left ○Both
Cervical Spine Surgery: ACDF
Cervical Spine Surgery: Disc Replacement
Distal Radius ORIF
○Right ○Left ○Both
Ganglion Cyst Excision
Intermedullary Nailing Femur
○Right ○Left ○Both
Intermedullary Nailing Tibia
○Right ○Left ○Both
Joint Replacement: Hip
○Right ○Left ○Both
Joint Replacement: Knee
○Right ○Left ○Both
Joint Replacement: Shoulder
○Right ○Left ○Both
Knee Arthroscopy
○Right ○Left ○Both
Kyphoplasty/Vertebroplasty
Lumbar Fusion
Lumbar Laminectomy
Lumbar Spine Surgery: Decompression
Lumbar Spine Surgery: Decompression & Fusion
Lumbar Spine Surgery: Disc Replacement
Meniscus Repair
○Right ○Left ○Both
Reverse Total Shoulder Replacement
○Right ○Left ○Both
Revision of Total Knee Arthroplasty
○Right ○Left ○Both
Revision of Total Shoulder Arthroplasty
○Right ○Left ○Both
Rotator Cuff Repair
○Right ○Left ○Both
Shoulder Arthroscopy
○Right ○Left ○Both
Trigger Finger Release
Location: ___________________________________
NONE
Other_______________________________________

Social History (please check all that apply):

Cigarette Smoking
- Never Smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily
  - # packs per day

Alcohol Use
- Do not drink alcohol
- Less than 1 drink a day
- 1-2 drinks a day
- 3 or more drinks a day

Exercise Frequency
- Several times a day
- Once a day
- Few times a week
- Few times a month

Medications (please list all current medications or check option which applies):

I brought a copy of my medication list (please provide the list to the front desk receptionist)
Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option which applies):

I brought a copy of my allergy list (please provide the list to the front desk receptionist)
No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Family History (please inform us of your family members' medical history by marking the appropriate box)**:**

	Mother	Father	Sister	Brother	Daughter	Son	Other:
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes, Type 2							
*Other*__________________________							

No Family History (checking this box indicates no past family medical history)

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No
Joint pains		
Joint swelling		
Joint stiffness		
Unsteady gait		
Numbness		
Tingling		
Unexpected weight loss		
Fever		
Chills		
Poor healing wounds		
Scarring/Keloids		
Easy bleeding		
Rash		
Immunosuppression		
Allergic reaction to foods/environment		
Chest pain		
Heart murmur		
Excessive thirst or urination		
Nose bleeds		
Corrective lenses		
Nausea/vomiting		
Diarrhea		
Difficult/painful urination		
Shortness of breath		
Anxiety		
Depression		
Patient is UNABLE to answer review of systems questions		

Alerts* (check yes or no for the following):

Alert	Yes	No
Pacemaker		
Blood thinners		
Defibrillator		
Premedication prior to procedures		
Rheumatoid Arthritis		
RSD		
Allergy to shellfish/iodine		
Allergy to latex		
Allergy to adhesive		
Under pain management		
Allergy to nickel		
Patient is UNABLE to answer		

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.