# Patient Intake Form

**Today's Date**: _____/_____/_____

**Patient Name:** _____ **Date of Birth**:_____/_____/_____

**Doctor or PA that you are seeing today:** _____

**Primary Care Doctor, PA/Nurse Practitioner**: _____

**Referring Doctor, PA/Nurse Practitioner**: _____

**Reason for Today's Visit:** _____
**(***which side? right, left, both***)**

**Email Address: None** ☐ **On File** ☐ _____

**Did you receive the influenza vaccine in the <u>current</u> flu season (September through March)?** ☐ Yes

**Or, did you receive the influenza vaccine <u>last</u> flu season?** ☐ Yes

**If you did NOT receive the influenza vaccine, was it:**

- ☐ due to patient allergy
- ☐ because patient refused
- ☐ because (other) _____

## ATTENTION PATIENTS 65 AND OLDER:

**Have you ever received a pneumonia vaccine?** ☐ No ☐ Yes

**Do you have a Living Will or Advance Directive?** ☐ No ☐ Yes

If yes, please name responsible person: _____

***Please complete, take this form with you for your appointment, and return to desk #5 or #6 when you are checking-out <u>after</u> your appointment. Thank you!***

OFFICE USE ONLY
FOLLOW UP: _____DAY(S) _____WEEK(S) _____MONTH(S) _____YEAR(S)
WITH _____ (IF DIFFERENT THEN PROVIDER PT SAW TODAY)

# Health History

**Patient Name:** _____ **Today's Date**:_____/_____/_____

**Doctor or PA that you are seeing today:**_____ **Date of Birth:**_____/_____/_____

**Past Medical History** - *Please check all that apply or check "None"*:

- ☐ **NONE**
- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (irregular heartbeat)
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Ischemic Heart Disease
- ☐ Chronic Pain
- ☐ COPD
- ☐ Colon Cancer
- ☐ Coronary Artery Disease
- ☐ History of blood clots (DVT)
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD (acid reflux)
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Hyperthyroidism (overactive thyroid)
- ☐ Hypothyroidism (underactive thyroid)
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke

Other *(Please list **non**-orthopedic issues here)*:

_____
_____
_____
_____
_____
_____

| Please List All Past Surgeries (include Orthopedic) | Date | Hospital/Facility | Surgeon |
|---|---|---|---|
| ☐ **NONE** | | | |
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**Past Orthopedic History** – *Please check all that apply or check "None"*:

- ☐ **NONE**
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Fractures *(where?)*

_____
_____

- ☐ Gout
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD (Reflex Sympathetic Dystrophy
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Soft Tissue Sarcoma
- ☐ Vitamin D Deficiency
- ☐ Back/Spine issues List below:

_____
_____

- ☐ Lupus
- ☐

Other_____
_____
_____
_____

**Date of Last Tetanus Shot:** _____

**Have you ever had a bone density (DXA) scan?** ○ **No** ○ **Yes Date**_____ **Where:** _____

**Medications -** *Please list all **current** medications including over the counter medication, vitamins, supplements, herbs, & prescribed medications, & recreational drugs***:**

☐ **NONE - Not currently taking any medications or supplements**

☐ I brought a copy of my medication list (please provide the list to the Orthopedic Assistant)

| Medication Name | Dosage | # times dosage taken per day |
|---|---|---|
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| ☐ **Medication list continued on back** | | |

**Preferred Pharmacy Name & Location:**_____

**Allergies:** ☐ **NONE - No known allergies**

| Please list all known allergies | Please describe allergic reaction severity & symptoms |
|---|---|
| | |
| | |
| | |
| | |

**Social History -** *Please check all that apply***:**

**Cigarettes/Tobacco Use**

- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily- # packs per day_____
- ☐ Chewing tobacco

*Would you like information to help you quit?*

☐ Yes ☐ No

**Alcohol Use**

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

*Would you like information on counseling?*

☐ Yes ☐ No

**Occupation:**_____

**Exercise Frequency**

- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other_____

**Other**

- ☐ Recreational Drug Use
- ☐ Live alone

**Family History –** *Please check all that apply or check "No Family History" or "Family History Unknown"***:**

| ☐ **No Family History** | | | | | | |
|---|---|---|---|---|---|---|
| ☐ **Family History Unknown** | **Mother** | **Father** | **Sister** | **Brother** | **Daughter** | **Son** |
| Cardiac disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gout | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alcoholism | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Alerts -** *Please check all that apply***:**

- ☐ History of Blood Clot(s) (DVT)
- ☐ On immunosuppressants
- ☐ Pregnancy or planning a pregnancy
- ☐ Blood Thinners
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Chronic infection
- ☐ Allergy to Iodine
- ☐ Allergy to Latex
- ☐ Metal Allergy
- ☐ Tobacco usage
- ☐ Seeing a Pain Management Specialist. If yes, who?

  _____
- ☐ Resides in a Skilled Nursing Facility
- ☐ **NONE**

***Please inform the provider or orthopedic assistant of any other medical conditions or concerns***