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
- ☐ 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**			

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 Cancer
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Soft Tissue Cancer
- ☐ Vitamin D Deficiency
- ☐ Back/Spine issues List below:

_____
_____

- ☐ Lupus
- ☐

Other_____

_____
_____
_____

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
☐ **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:_____

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**
Blood Clots	☐	☐	☐	☐	☐	☐
Malignant Hyperthermia	☐	☐	☐	☐	☐	☐

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
- ☐ Have you ever been diagnosed with COVID?
  ☐ Yes ☐ No
- ☐ 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