History & Intake Form Date: _____ Patient Name: _____DOB:_____

Primary Care Provider:_____

Referring Provider:_____

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

Past Medical History (please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ 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
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Stroke
- ☐ Other_____ _____
- ☐ **None**

Past Surgical History (please check all that apply & add the year surgery was performed):

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

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
- ☐ Soft Tissue Sarcoma
- ☐ Spine Fracture
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ Other_____
- ☐ **None**

Past Orthopedic Surgery (please check all that apply and add the hospital and date of surgery):

Hospital/Surgeon/Date

- ☐ Ankle Fracture Surgery _____ ○Right ○Left ○Both
- ☐ Carpal Tunnel Decompression _____ ○Right ○Left ○Both
- ☐ Cervical Spine Surgery: ACDF_ _____
- ☐ Cervical Spine Surgery: Disc Replacement _____
- ☐ Distal Radius Fracture Surgery _____ ○Right ○Left ○Both
- ☐ Intermedullary Nailing Femur _____ ○Right ○Left ○Both
- ☐ Intermedullary Nailing Tibia _____ ○Right ○Left ○Both
- ☐ Joint Replacement: Hip _____ ○Right ○Left ○Both
- ☐ Joint Replacement: Knee _____ ○Right ○Left ○Both

Hospital/Surgeon/Date

- ☐ Joint Replacement: Shoulder _____ ○Right ○Left ○Both
- ☐ Knee Arthroscopy _____ ○Right ○Left ○Both
- ☐ Kyphoplasty/Vertebroplasty _____
- ☐ Lumbar Spine Surgery: Decompression _____
- ☐ Lumbar Spine Surgery: Decompression & Fusion _____
- ☐ Lumbar Spine Surgery: Disc Replacement _____
- ☐ Rotator Cuff Repair ○Right ○Left ○Both _____
- ☐ Other_____ _____
- ☐ **None**

Medications (please list all current medications including over the counter medication, vitamins, herbs, & prescribed medications, & recreation drugs):

- ☐ 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):

- ☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Pharmacy Information

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

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

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
- ☐ Chewing tobacco

Occupation:_____

Family History (please inform us of your family members' medical history by marking the appropriate box and indicating which family member (Mother, Father, Sister, Brother, Daughter, Son)**:**

- ☐ Heart Trouble _____
- ☐ High Blood Pressure _____
- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Arthritis _____
- ☐ Gout _____
- ☐ Seizures _____
- ☐ Mental Illness _____
- ☐ Kidney Trouble _____
- ☐ Bleeding _____
- ☐ Alcoholism _____
- ☐ Cancer _____

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

Review of Systems (check if you are **currently** experiencing any of the following):

- ☐ Fever / Chills
- ☐ Night Sweats
- ☐ Depression
- ☐ Anxiety
- ☐ Nose Bleeds
- ☐ Blurred Vision
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Nausea / Vomiting
- ☐ Heartburn
- ☐ Urinary Incontinence
- ☐ Frequent Urination
- ☐ Joint Swelling
- ☐ Joint Pains
- ☐ Unsteady Gait
- ☐ Seizures
- ☐ Weakness
- ☐ Rash
- ☐ Poor Healing Wounds
- ☐ Easy Bleeding/Bruising
- ☐ Chronic Infection
- ☐ Excessive Thirst or Urination
- ☐ **None**

Alerts (please check all that apply)
- ☐ History of Blood Clot(s) {DVT}
- ☐ Pregnancy or Planning a Pregnancy
- ☐ Blood Thinners
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Allergy to Shellfish/Iodine
- ☐ Allergy to Latex
- ☐ Metal Allergy
- ☐ Tobacco Usage
- ☐ Seeing a Pain Management Specialist

Height (in inches): _____ **Weight**: _____ lbs.

(be honest as medical decisions may be made with this information such as prescription dosages).

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