Orthopedic Intake

Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: Male or Female

What are we seeing you for? _____

_____

Have you had Flu vaccine? ❑ Yes ❑ No Date_____ Pneumonia vaccine? ❑ Yes ❑ No Date_____

List of Past Surgeries: _____

_____

_____

List all Prescriptions and over the counter Medications: _____

_____

_____

Is this work related? ❑ Yes ❑ No MVA ❑ Yes ❑ No

Social History:

Most Recent Occupation: _____

Do you live alone? _____

Do you use tobacco? _____

If yes, packs per day _____

Do you drink alcohol? _____

If yes, drinks per day _____

Family History:

Cancer Heart Attack
Diabetes Stroke

Review of Systems: In the past 30 days have you experienced any of the following:

Fever/Chills	Yes	No
Chest Pains	Yes	No
Dizziness	Yes	No
Swelling in the legs	Yes	No
Bruising	Yes	No
Bleeding	Yes	No
Joint Pain/Stiffness	Yes	No
Muscle Pain/Stiffness	Yes	No
Seizure	Yes	No

You are __ R handed __ L handed

Allergies:

None _____

Adhesive Tape	Yes	No
Codeine	Yes	No
Latex	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No
Dye/Iodine	Yes	No

Other:

_____

_____

_____

_____

_____

Past Medical History:

Anemia
Asthma
Coronary Heart Disease
Depression
Diabetes
Type 1___ Type 2___
DVT
Gerd/Reflux
GI Bleed
Hepatitis A, B, C
High Blood Pressure
HIV
Hypothyroidism
Kidney Disease
Liver Disease
Neurological Disorder
Osteoarthritis
Osteoporosis
Pulmonary Embolism
Rheumatoid Arthritis
Seizures Disorder
Stroke