Orthopaedic Intake

Date: ____________________

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

What are we seeing you for? ____

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

List of Past Surgeries: ____

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List all Prescriptions and over the counter Medications: ____

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Is this work related? ❑ Yes ❑ No MVA ❑ Yes ❑ No Date of Injury: ______________________

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:

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Past Medical History:

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