HISTORY INTAKE FORM

Patient Name: ______________________________

Date of Birth: ______________________ Age: ______

☐ Right-handed ☐ Left-handed Occupation (If retired, past profession): ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary care Dr.: ______________________ Referring Dr. (*if different*): ______________________

Do you smoke? ☐ Yes ☐ No Packs/day ______
Are you a former smoke? ☐ Yes ☐ No If yes, when did you quit? ______________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? ______________________

Body part being seen for: ____________ ☐ Right ☐ Left Date of Onset of symptoms: ____________

Brief description of injury: ____

____

Please rate your pain (0=none, 10=worst): ______

How is your current problem limiting you?

____

____

Are you taking medications specifically for this? ☐ Yes ☐ No If so, which medications? ____________

____

Please list **ALL** medical problems (heart, lungs, diabetes, cancer, etc.): ______________________

____

____

Please list **ALL** previous surgeries (orthopaedic AND non-orthopaedic):______________________

____

____

Do you have or have you had any of the following?

☐ MRSA/MSSA ☐ Blood Clot ☐ Blood Disorder ☐ Cancer ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Gout

Does any first-degree **blood relative** have or has had any of the following (check box):

	Mother	Father	Brother	Sister
Diabetes				
Rheumatoid Arthritis				
Osteoarthritis				
Blood Clots				
Blood Disorder				

OFFICE USE ONLY

Weight: ______

Height: ______

BMI: ______

REVIEW of Systems (Check all that apply currently to you):

☐ Joint/Limb Pain ☐ Numbness/Tingling ☐ Fever/Chills ☐ Chest Pain
☐ Shortness of Breath ☐ Non-healing Wound ☐ Acid Reflux ☐ Easy Bleeding

HISTORY INTAKE FORM

Patient Name: ______________________________

Pharmacy of Choice: ______________________________

ALLERGIC to (check all that apply): ☐ LATEX ☐ METAL ☐ IODINE/SHELLFISH

LIST MEDICATION ALLERGIES and the allergic REACTION:

Medication	Reaction	Medication	Reaction
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

CURRENT MEDICATIONS/ SUPPLEMENTS (name of medication and dosage):

Medication	Dosage	Frequency	Medication	Dosage	Frequency
1.			16.		
2.			17.		
3.			18,		
4.			19.		
5.			20.		
6.			21.		
7.			22.		
8.			23.		
9.			24.		
10.			25.		
11.			26.		
12.			27.		
13.			28.		
14.			29.		
15.			30.		

The above information is accurate to the best of my knowledge:

Patient Signature ______________________________ Date: ______________