History & Intake Form **Print Name:** ______________________________

Preferred Language: ______________________________ Race: _______________ Ethnicity: _______________

Preferred Pharmacy Name & Address: ____

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 Dependant
- ◻ Diabetes, Non Insulin Dependant
- ◻ End Stage Renal Disease
- ◻ GERD
- ◻ Hepatitis
- ◻ HIV/AIDS
- ◻ High Cholesterol
- ◻ Hyperparathyroidism
- ◻ Hypertension
- ◻ Hypothyroidism
- ◻ 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):

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

Past Orthopedic History (please check all that apply):

- ◻ Ankle Fracture
- ◻ Bursitis
- ◻ Epidural Injections, Spine
- ◻ Fracture ____________________
- ◻ Gout
- ◻ Hip Fracture
- ◻ HNP, Cervical
- ◻ HNP, Lumbar
- ◻ Metastatic Bone Disease
- ◻ Osteoarthritis
- ◻ Osteopenia
- ◻ Osteoporosis
- ◻ Primary Bone Sarcoma
- ◻ Psoriatic Arthritis
- ◻ Rheumatoid Arthritis
- ◻ Rickets
- ◻ RSD
- ◻ Sciatica
- ◻ Scoliosis
- ◻ Spine Fracture
- ◻ Soft Tissue Sarcoma
- ◻ Spinal Stenosis, Cervical
- ◻ Spinal Stenosis, Lumbar
- ◻ Vitamin D Deficiency
- ◻ Wrist Fracture
- ◻ Other ____________________
- ◻ None

Past Orthopedic Surgery (please check all that apply):

- ☐ Ankle Fracture ORIF
  - ○ Right ○Left ○ Both
- ☐ Carpal Tunnel Decompression
  - ○ Right ○Left ○ Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF
  - ○ 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
- ☐ 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 or check option which applies:

- ☐ 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 or check option which applies):

- ☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
- ☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Family History (please inform us of your family members' medical history by marking the appropriate box):

	Mother	Father	Sister	Brother
Liver or Kidney Disease (circle one)				
Heart Disease				
Lung Disease				
Cancer				
Diabetes				
Other				

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

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 a day

Review of Systems* (check yes or no if you are *currently* experiencing any of the following):

Symptom	Yes	No
Joint Pain		
Joint Swelling		
Joint Stiffness		
Unsteady Gait		
Numbness		
Tingling		
Fever		
Chills		
Skin Rash		
Easy Bleeding (currently experiencing)		
Chest Pain		
Excessive thirst or urination		
Heat/Cold Intolerance		
Nose Bleeds		
Constipation		
Shortness of breath		
Anxiety		

Alerts* (check yes or no for the following):

Alert	Yes	No
BLOOD THINNERS		
PACEMAKER		
DEFIBRILLATOR		
ALLERGY TO SHELLFISH/IODINE		
ALLERGY TO IODINE		
ALLERGY TO ADHESIVE		

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