

Intake Form

Regional Physicians Orthopaedics

Patient Name _____ DOB _____

Primary Care Physician: _____

Who referred you? _____

Pharmacy: _____ **Pharmacy #:** _____

Current Active Problems:

Reason for this visit: _____

Main problem you wish to discuss today: _____

Past medical history: None _____

Mark/Circle **ALL** if you have ever experienced any of the following symptoms

- | | |
|--|---|
| Y N Asthma | Y N High Blood Pressure { <i>Hypertension</i> } |
| Y N Bleeding Disorder { <i>Which type</i> } _____ | Y N HIV/AIDS |
| Y N Blood Clots | Y N Hepatitis |
| Y N COPD | Y N Kidney Disease |
| Y N Depression | Y N Liver Disease |
| Y N Diabetes | Y N Respiratory Problems |
| Y N Elevated Cholesterol { <i>Hypercholesterolemia</i> } | Y N Seizures Disorders |
| Y N Fainting Spells | Y N Stroke |
| Y N Heart Disease | Y N Thyroid Problems |

List all other medical problems that are not listed above:

Past Surgical History with dates or hospitalizations - *Ask for more sheets if you need them*

No past Surgeries (X) _____

List any ongoing therapy (PT, Chiropractor, massage, acupuncture etc)

Social History:

Adults: single __ married__ divorced__ widowed__

Do You Smoke or use other Tobacco products__ Alcohol Use _____

Drug use: marijuana/cocaine/narcotics__are you or have you ever been under treatment for alcohol or drug dependence? _____ Support person _____

History of IV Drug Use? _____

Sports or extracurricular activities: _____

TURN SHEET OVER

Family History: None_____

Please Mark/Circle **All**. Family includes your parents, children, siblings, aunts and uncles related by blood

- | | |
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Y N Cancer- If yes what type? _____

List other medical problems that are in your family that are not listed above:

Allergies: None_____

Are you allergic to any medications, foods, bees, latex or contrast dye? _____

If so, what? _____

Medications: None_____

List all medications including occasional, Herbal, vitamins and over the counter.

Patient Sign and Date

Regional Physicians Orthopedics - Review of Systems

NAME: _____ DATE: _____ DOB: _____

Please **MARK /CIRCLE Yes or No to each item** to indicate which of the follow symptoms you are experiencing :

Musculoskeletal

- Y N Joint Stiffness
- Y N Joint Pain
- Y N Osteoporosis
- Y N Joint Swelling
- Y N Back Pain
- Y N Gout
- Y N Rheumatoid Arthritis
- Y N Limb Swelling
- Y N Ankle Swelling

Gastrointestinal

- Y N Heartburn
- Y N Gastric Ulcer
- Y N Nausea
- Y N Vomiting
- Y N Blood in stool
- Y N Liver, Stomach or Bowel Disorder
- Y N Hepatitis

Endocrine

- Y N Excessive Thirst
- Y N Excessive Urination
- Y N Temperature Intolerance
- Y N Thyroid Disorder
- Y N Diabetes Mellitus

Constitutional

- Y N Weight Loss _____ Lbs.
- Y N Fever
- Y N Decreased Appetite

Eyes

- Y N Blurry Vision
- Y N Double Vision
- Y N Visual Impairment

Ears, Nose, Throat

- Y N Loss of Hearing
- Y N Hoarseness

Cardiovascular

- Y N Chest Pain
- Y N Palpitations
- Y N Heart Disease
- Y N Hypertension

Respiratory

- Y N Chronic Cough
- Y N Shortness of Breath
- Y N Wheezing

Genitourinary

- Y N Painful Urination
- Y N Blood in Urine
- Y N Renal Disorder

Integumentary

- Y N Skin Rash
- Y N Skin Lesions
- Y N Skin Lump
- Y N Psoriasis
- Y N Skin Wound

Neurological

- Y N Headaches
- Y N Dizziness
- Y N Seizures
- Y N Dementia

Psychosocial

- Y N Depression
- Y N Alcohol Use
- Y N Drug Use
- Y N Sleep Disturbances

Hematologic/Lymphatic

- Y N Easy Bleeding
- Y N Easy Bruising
- Y N Anemia
- Y N HIV/AIDS