Name:
DOB:
Acct #:
Age:
Date:

Orthopaedics OF STEAMBOAT SPRINGS

Patient Intake Form

Patient Information

Patient's Full Name _____ Date _____ ☐ Male ☐ Female

Date of Birth _____ Age _____ SSN# _____

Employer: _____ Years employed with current employer _____

Health Information

Past Medical History:

Have you had any medical problems? ☐ Yes ☐ No

High Blood Pressure	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Gastritis/Ulcers	☐ Yes	☐ No
Asthma/Emphysema	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Other	☐ Yes	☐ No _____

Past Surgical History:

Please list any surgeries you've had.

_____ Date _____
_____ Date _____
_____ Date _____

Social History:

Former tobacco user: ☐ No ☐ Yes(smoker) ☐ Yes(other)

Do you currently use…

Tobacco ☐ Yes ☐ No Packs per day _____

Alcohol ☐ Yes ☐ No Amount _____

Past or present chemical dependency ☐ Yes ☐ No

Medications:

List all medicatons you are currently taking.

- _____
- _____
- _____
- _____
- _____
- _____

Allergies:

List all drugs to which you are allergic. ☐ **None known**

- _____ Reaction _____
- _____ Reaction _____
- _____ Reaction _____
- _____ Reaction _____

Family History:

Has anyone in your family had any of these conditions?

Stroke	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Other	☐ Yes	☐ No _____

Hobbies: _____

Review of Systems:

Constitutional/General:			Cataracts	☐ Yes	☐ No	Foods	☐ Yes	☐ No
Weight Gain/Loss	☐ Yes	☐ No	**Gastrointestinal:**			Adhesive, dye, iodine	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Stomach Pain	☐ Yes	☐ No	**Musculoskeletal:**		
Cardiovascular:			Diarrhea	☐ Yes	☐ No	Joint Swelling	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Persistent Vomiting	☐ Yes	☐ No	Joint Pain	☐ Yes	☐ No
Irregular Heart Beat	☐ Yes	☐ No	**Hematological:**			Muscle Aches	☐ Yes	☐ No
Poor Circulation	☐ Yes	☐ No	Bleeding Problems	☐ Yes	☐ No	**Endocrine:**		
Neurological:			Blood Transfusion	☐ Yes	☐ No	Thyroid Problems:	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No	Blood Clots	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	**Psychiatric:**			Other		
Respiratory:			Bipolar Disease	☐ Yes	☐ No	**Skin:**		
Shortness of breath	☐ Yes	☐ No	Depression	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No	**Ears, Nose, Throat:**			Dryness of skin	☐ Yes	☐ No
Persistent Cough	☐ Yes	☐ No	Loss of hearing	☐ Yes	☐ No	**Genitourinary:**		
Eyes:			Sinus problems	☐ Yes	☐ No	Blood in urine	☐ Yes	☐ No
Decreased Vision	☐ Yes	☐ No	**Allergies:**			Pain with urination	☐ Yes	☐ No

Patient/Guardian Signature: _____ **Date:** _____

Reviewed by: _____ **Initials** _____ **Date**

Reviewed by: _____ **Initials** _____ **Date**