

Tri-County Orthopaedic & Sports Medicine, P.A. Confidential History Intake Form

Patient Name _____	Date of Birth _____ / _____ / _____	Today's Date _____ / _____ / _____
Phone Number _____	New Patient to the Practice Established Patient to the Practice	

Primary Physician: _____ Phone #: _____

What is the reason for today's visit? Left () Right () _____

How did this problem occur? _____

When/where did this happen? _____

Have you had X-rays taken for this problem? Yes No If yes, indicate date/place: _____

Have you had physical therapy for this problem? Yes No If yes, for how long: _____

Have you tried any medications for this problem? Yes No If yes, list names: _____

Past Medical History:

Do you have (or have you had) any of the following medical problems? **OR CHECK** **NONE**

- | | | |
|--|----------------------------|--------------------|
| High Blood Pressure | Ulcers/Stomach Bleeding | Asthma |
| Diabetes | Kidney Failure/One Kidney | Migraine Headaches |
| Heart Disease (Heart Attack/Stent Placement) | Seizures | Depression |
| Stroke/TIA | Alcoholism/Substance Abuse | Bipolar Disorder |
| Breast cancer | Prostate cancer | Osteoporosis |
| OTHER Medical History _____ | | |

Height: ____ ft. ____ in. Weight: ____ lbs.

Have you ever had a **blood clot** or **deep venous thrombosis**? Yes No If yes, please explain: _____

Past Surgical History:

Have you had any type of surgery? Yes No If yes, please list: _____

Allergies:

Do you have any medication allergies? Yes No If yes, please explain your reaction: _____

Medications:

Do you regularly take any medications? Yes No If yes, please list: _____

Social History:

Occupation/School: _____

Do you smoke? No Yes, ____ cig/day for ____ years

Do you drink alcohol? No Yes, ____ drinks/day OR ____ drinks/wk OR ____ occasional use

Family History:

List any medical problems that run in your family: _____

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Review of Systems: Please check if you currently have any of the following: **OR CHECK** **NONE**

- | | | | | | |
|---------------------------|-----|----|-------------------------|-----|----|
| ● Unexpected weight loss? | Yes | No | ● Diarrhea? | Yes | No |
| ● Unexpected weight gain? | Yes | No | ● Nausea/Vomiting? | Yes | No |
| ● Visual changes? | Yes | No | ● Constipation? | Yes | No |
| ● Fevers? | Yes | No | ● Pain with urination? | Yes | No |
| ● Headaches? | Yes | No | ● Frequent urination? | Yes | No |
| ● Cold sores? | Yes | No | ● Incontinence? | Yes | No |
| ● Coughing? | Yes | No | ● Rashes? | Yes | No |
| ● Wheezing? | Yes | No | ● Breast pain? | Yes | No |
| ● Shortness of breath? | Yes | No | ● Nipple discharge? | Yes | No |
| ● Phlebitis? | Yes | No | ● Lumps in breast? | Yes | No |
| ● Chest pains? | Yes | No | ● Blood sugar problems? | Yes | No |
| ● Palpitations? | Yes | No | ● Thyroid problems? | Yes | No |
| ● Leg Swelling? | Yes | No | ● Severe night sweats? | Yes | No |
| ● Mood Changes? | Yes | No | | | |
| ● Depression? | Yes | No | | | |
| ● Anxiety? | Yes | No | | | |

X _____
Patient Signature

Date

X _____
MD Signature

Date

To be completed by the physician

Date reviewed: _____	Any Changes?	Yes	No	_____
				MD Signature
Date reviewed: _____	Any Changes?	Yes	No	_____
				MD Signature
Date reviewed: _____	Any Changes?	Yes	No	_____
				MD Signature
Date reviewed: _____	Any Changes?	Yes	No	_____
				MD Signature
Date reviewed: _____	Any Changes?	Yes	No	_____
				MD Signature