PATIENT INTAKE FORM – BURKE & BRADLEY ORTHOPEDICS

Patient Name: ___________________________

DOB: ____________________________________

OFFICE USE: PLEASE REPLACE WITH PATIENT STICKER

PERSONAL INFORMATION

FAMILY DOCTOR:	REFERRED BY:	
OCCUPATION:		
COMPLAINT / INJURY (LEFT OR RIGHT):		
DATE OF INJURY:	HOW DID INJURY OCCUR?	
HEIGHT:	WEIGHT:	RIGHT OR LEFT HANDED (CIRCLE ONE)

PREFERRED PHARMACY: ____

MEDICATION DOCUMENTATION (PRESCRIBED, HERBAL, OVER-THE-COUNTER)

MEDICATION NAME	DOSING AND INSTRUCTIONS	START DATE

ALLERGIES

ALLERGIES	REACTION	NOTED

☐ I HAVE NO KNOWN ALLERGIES

Revised 12/22/2016

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MEDICAL HISTORY (Please check all that apply)

☐ SLEEP APNEA	☐ MIGRAINE HEADACHES	☐ DEEP VEIN THROMBOSIS
☐ KIDNEY DISEASE	☐ SEIZURES	☐ ANEMIA
☐ CANCER (Type)	☐ ASTHMA	☐ INFLAMMATORY BOWEL DISEASE
☐ THYROID DISEASE	☐ COPD	☐ FIBROMYALGIA
☐ HEART ATTACK	☐ PULMONARY EMBOLISM	☐ PARKINSON'S DISEASE
☐ HEART DISEASE	☐ PEPTIC ULCER DISEASE	☐ DISC DISEASE
☐ HIGH CHOLESTEROL	☐ GALLBLADDER / BILLARY DISEASE	☐ RHUEMATOID ARTHRITIS
☐ HEART ARRTHYMIIAS	☐ GERD	☐ GOUT
☐ STROKE	☐ LIVER / HEPATITIS DISEASE	☐ PSYCHIATRIC OR BEHAVIORAL PROBLEMS
☐ PACEMAKER INSERTION	☐ DIABETES MELLITUS	☐ DEPRESSION
☐ HIGH BLOOD PRESSURE		

SURGICAL HISTORY (Please check all that apply)

☐ SHOULDER SURGERY	☐ CRANIOTOMY
☐ ELBOW SURGERY	☐ INTRATHECAL PUMP
☐ HAND / WRIST SURGERY	☐ VENTRICULAR SHUNT
☐ HIP SURGERY	☐ SPINAL CORD STIMULATOR
☐ KNEE SURGERY	☐ THYROID SURGERY
☐ FOOT / ANKLE SURGERY	☐ APPENDECTOMY
☐ SPINE SURGERY	☐ CHOLECYSTECTOMY
☐ PACEMAKER	☐ HYSTERECTOMY
☐ ICD	☐ CABG (CORONARY ARTERY BYPASS GRAFTING)
☐ ADVERSE REACTION TO ANESTHESIA	☐ CORONARY ARTERY STENT
☐ ENDARTERECTOMY	

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FAMILY HISTORY

Does anyone in your family have these conditions? Check yes or no to the following for your blood relatives (mother, father, brothers, sisters, sons, daughters, aunts, uncles, grandparents), DO NOT INCLUDE YOURSELF.

RELATIONSHIP	ADVERSE ANESTHESIA	ANEURYSM	ASTHMA	BLEEDING DISORDERS	BRAIN TUMOR	CANCER	DEMENTIA	DIABETES	HEART DISEASE	HYPERTENSION	MENTAL ILLNESS	MIGRAIN	PARKINSONS DISEASE	PEPTIC ULCER DISEASE	SEIZURES	STROKE	TUBERCULOSIS	VASCULAR MALFORMATION	OTHER	NO FAMILY HISTORY
MOTHER																				
FATHER																				
MATERNAL GRANDMOTHER																				
MATERNAL GRANDFATHER																				
PATERNAL GRANDMOTHER																				
PATERNAL GRANDFATHER																				
SISTER																				
BROTHER																				
DAUGHTER																				
SON																				
OTHER																				

☐ **ADOPTED FAMILY** ☐ **HISTORY UNKNOWN**

SOCIAL HISTORY

TOBACCO USE: **YES / NO**	HOW MANY PACKS/DAY?	FOR HOW MANY YEARS?	READY TO QUIT? **YES / NO**	DATE QUIT?
SMOKELESS TOBACCO USE? **YES / NO**				
ALCOHOL USE? **YES / NO**	AMOUNT/TYPE/HOW OFTEN			
DRUG USE? **YES / NO**	AMOUNT/TYPE/HOW OFTEN			
MARITAL STATUS **SINGLE / MARRIED / DIVORCED / WIDOW / SEPARATED / OTHER**				

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REVIEW OF SYSTEMS **(Please check all that apply)**

CONSTITUTIONAL	**EYES**	**GASTROINTESTINAL**	**ENDOCRINE**
☐ FEVER	☐ BLINDNESS	☐ NAUSEA	☐ HYPOTHYROIDISM
☐ WEIGHT LOSS	**HEME/LYMPH**	☐ VOMITING	☐ DIABETES
☐ WEIGHT GAIN	☐ BRUISES / BLEEDS EASILY	**GENITOURINARY**	**CARDIOVASCULAR**
☐ NIGHT SWEATS	**RESPIRATORY**	☐ URGENCY	☐ CHEST PAIN
SKIN	☐ SLEEP APNEA (Brief stops in breathing)	☐ FREQUENCY	☐ LEG SWELLING
☐ HIVES	☐ SHORTNESS OF BREATH	**MUSCULOSKELETAL**	**PSYCHIATRIC**
HENT	**NEUROLOGICAL**	☐ MUSCLE WEAKNESS	☐ NERVOUS / ANXIOUS
☐ HEARING LOSS	☐ HEADACHE	☐ FALLS	☐ DEPRESSION
ALLERGY/IMMUNO	☐ NUMBNESS/TINGLING	☐ JOINT PAIN	
☐ ENVIRONMENTAL ALLERGIES	☐ LIGHTHEADEDNESS	☐ MUSCLE PROBLEMS	
OTHER (PLEASE SPECIFY)			

☐ **I am having none of these symptoms at this time.**

Provider Reviewed: ____ **Date:** ___________________

Revised 12/22/2016