# PATIENT INTAKE FORM – BURKE & BRADLEY ORTHOPEDICS

OFFICE USE: PLACE PATIENT STICKER

**Name:**_____

**DOB:**_____

## 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)** |

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

| MEDICATION NAME | DOSING AND INSTRUCTIONS |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**PREFERRED PHARMACY:** _____

## ALLERGIES

| ALLERGIES | REACTION |
|---|---|
| | |
| | |
| | |
| | |
| | |

☐ **I HAVE NO KNOWN ALLERGIES**

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## MEDICAL HISTORY (Please check all that apply)

| | | |
|---|---|---|
| ☐ Acid Reflux Disease | ☐ Disc Disease | ☐ Myocardial Infarction (Heart Attack) |
| ☐ Anemia | ☐ Fibromyalgia | ☐ Osteoarthritis |
| ☐ Anxiety | ☐ Gout | ☐ Osteoporosis |
| ☐ Apnea | ☐ Heart Arrhythmia | ☐ Parkinson's Disease |
| ☐ Arthritis | ☐ Heart Disease | ☐ Peptic Ulcer |
| ☐ Asthma | ☐ High Blood Pressure | ☐ Peripheral Arterial Occlusive Disease |
| ☐ Biliary Disease | ☐ High Cholesterol | ☐ Pulmonary Disease |
| ☐ Cancer | ☐ Inflammatory Bowel Disease | ☐ Pulmonary Embolism |
| ☐ Clotting Disorder | ☐ Kidney Disease | ☐ Rheumatoid Arthritis |
| ☐ COPD | ☐ Liver Disease | ☐ Seizures |
| ☐ Deep Vein Thrombosis | ☐ Mental Disorder | ☐ Stroke |
| ☐ Depression | ☐ Migraine Headaches | ☐ Thyroid Disorder |
| ☐ Diabetes Mellitus | ☐ Muscular Dystrophy | ☐ Viral Hepatitis |

**OTHER MEDICAL HISTORY (please list):** _____

_____

## SURGICAL HISTORY (Please check all that apply)

| | | |
|---|---|---|
| ☐ Adenoidectomy | ☐ Coronary Artery Stent | ☐ Intrathecal Pump Implantation |
| ☐ Adverse Reaction to Anesthesia | ☐ Craniotomy | ☐ Knee Surgery |
| ☐ Ankle Surgery | ☐ Elbow Surgery | ☐ Shoulder Surgery |
| ☐ Appendectomy | ☐ Eye Surgery | ☐ Spinal Cord Stimulator |
| ☐ CABG | ☐ Foot Surgery | ☐ Spine Surgery |
| ☐ Cardiac Defibrillator Placement | ☐ Hand Surgery | ☐ Thyroid Surgery |
| ☐ Cardiac Pacemaker Placement | ☐ Hernia Repair | ☐ Tonsillectomy |
| ☐ Carotid Endarterectomy | ☐ Hip Surgery | ☐ Ventricular Surgery |
| ☐ Cholecystectomy | ☐ Hysterectomy | ☐ Wrist Surgery |

**OTHER SURGICAL History (please list):** _____

_____

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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. DO NOT INCLUDE YOURSELF.**

- **A = alive; D = deceased**

| RELATIONSHIP | STATUS* | No Family History | Adverse Reaction to Anesthesia | Alcohol Abuse | Anxiety | Arthritis | Asthma | Autoimmune Disorder | Bleeding Disorders | Blood Clotting Disorder | Cancer, Breast | Cancer, Colon | Cancer, Lung | Cancer, Ovarian | Cancer, Skin Melanoma | COPD | Dementia/Neurocognitive Disorder | Depression | Diabetes | Drug Abuse | Heart Disease | Hypertension | Kidney Disease | Liver Disease | Mental Illness | Obesity | Osteoporosis | Stroke | Thyroid Disease | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Mother** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Father** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Sister** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Brother** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Daughter** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Son** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MGMo** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PGMo** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MGFa** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PGFa** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MAunt** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PAunt** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MUnc** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PUnc** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Other:** _____

_____

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

# PATIENT INTAKE FORM – BURKE & BRADLEY ORTHOPEDICS

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| Smoking Tobacco Use: | | | Smokeless Tobacco Use | | |
|---|---|---|---|---|---|
| ☐ Current Smoker | Start Date | | ☐ Current User | ☐ Former User | ☐ Never Used |
| ☐ Former Smoker | Quit Date | | ☐ Chew | ☐ Snuff | |
| ☐ Never Smoker | | | Quit Date: | | |
| ☐ Cigarettes | ☐ Pipe | ☐ Cigars | | | |
| Packs per day: | Years: | | | | |

| Vaping Use: | | |
|---|---|---|
| ☐ Current Everyday User | ☐ Current Some Day User | ☐ Former User |
| ☐ Never Used | Cartridges/Day: | |
| Start Date: | Quit Date: | |

| Alcohol Use: | | | | | |
|---|---|---|---|---|---|
| | ☐ Yes | ☐ Not Currently | ☐ Never | | |
| How often do you have a drink containing alcohol? | ☐ Never | ☐ Monthly | ☐ 2-4X a month | ☐ 2-3X a week | ☐ 4 or more times a week |
| How many drinks containing alcohol do you have on a typical day when drinking? | ☐ 1 or 2 | ☐ 3 or 4 | ☐ 5 or 6 | ☐ 7 to 9 | ☐ 10 or more |
| How often do you have six or more drinks on one occasion? | ☐ Never | ☐ <Monthly | ☐ Monthly | ☐ Weekly | ☐ Daily or almost daily |
| Drinks/Week | | | | | |
| Glasses of wine: | | | | | |
| Cans of Beer: | | | | | |
| Shots of Liquor: | | | | | |

| Substance Use: | | | | | |
|---|---|---|---|---|---|
| ☐ Yes | ☐ Not Currently | | ☐ Never | | |
| Types: (Circle any that apply) | | | | | |
| IV | Methamphetamines | Benzodiazepines | Cocaine/Crack | Heroin | Marijuana |
| PCP | LSD | Other | Amphetamines | Amyl Nitrate | Anabolic Steroids |
| Barbiturates | Codeine | Fentanyl | Flunitrazepam | GHB | Hydrocodone |
| Hydromorphone | Ketamine | MDMA (Ecstasy) | Mescaline | Methaqualone | Methylphenidate |
| Morphine | Nitrous Oxide | Opium | Oxycodone | Psilocybin | Solvent Inhalants |
| Uses/ Week | | | | | |

| Caffeine Use: | | | | | |
|---|---|---|---|---|---|
| ☐ Never | ☐ Rarely | | ☐ Weekly | ☐ Daily | |
| ☐ Coffee | ☐ Tea | ☐ Soda | ☐ Energy Drinks | ☐ Caffeine Tablets | ☐ Other |

## PATIENT INTAKE FORM – BURKE & BRADLEY ORTHOPEDICS

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**REVIEW OF SYSTEMS** **(Please check all that you are experiencing today or on date of appointment)**

| 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: _____**

12/2019