MISSOULA Bone & Joint & Surgery Center

History & Intake Form

Today's Date: _____/_____/_____

Patient Name: _____ **Date of Birth**:_____/_____/_____

Doctor or PA that you are seeing today:_____

Primary Care Doctor, PA/Nurse Practitioner:_____

Referring Doctor, PA/Nurse Practitioner:_____

Reason for Today's Visit: _____
(*which side? right, left, both***)**

Past Medical History - *Please check all that apply or check "None"*:

- ☐ **None**
- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (irregular heartbeat
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Ischemic Heart Disease
- ☐ Chronic Pain
- ☐ COPD
- ☐ Colon Cancer
- ☐ Coronary Artery Disease
- ☐ History of blood clots (DVT)
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia (high cholesterol)
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke

Other *(Please list **non**-orthopedic issues here):*

_____
_____
_____
_____
_____

Please List All Past Surgeries (include Orthopedic)	Date	Hospital/Facility	Surgeon
☐ **None**			

Past Orthopedic History – *Please check all that apply or check "None"*:

- ☐ **None**
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ Fractures *(where?)*

_____
_____

- ☐ Gout
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD (Reflex Sympathetic Dystrophy
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Soft Tissue Sarcoma
- ☐ Vitamin D Deficiency
- ☐ Back/Spine issues List below:

_____
_____

- ☐ Lupus
- ☐ Other_____

_____
_____
_____

Have you ever had a bone density (DXA) scan? ☐ No ☐ Yes Date_____ Where:_____

Medications - *Please list all **current** medications including over the counter medication, vitamins, supplements, herbs, & prescribed medications, & recreational drugs*:

☐ **Not currently taking any medications or supplements**

☐ I brought a copy of my medication list (please provide the list to the Orthopedic Assistant)

Medication Name	Dosage	# times dosage taken per day
☐ **Medication list continued on back**		

Date of Last Tetanus Shot:_____

Preferred Pharmacy Name & Location:_____

Allergies: ☐ No known allergies

Please list all known allergies	Please describe allergic reaction severity & symptoms

Social History - *Please check all that apply*:

Cigarettes/Tobacco Use

- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily- # packs per day_____
- ☐ Chewing tobacco

Would you like information to help you quit?

☐ Yes ☐ No

Alcohol Use

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Would you like information on counseling?

☐ Yes ☐ No

Occupation:_____

Exercise Frequency

- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other_____

Other

- ☐ Recreational Drug Use
- ☐ Live alone

Family History – *Please check all that apply or check "No Family History"*:

☐ No Family History	Mother	Father	Sister	Brother	Daughter	Son
Heart trouble	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Kidney trouble	☐	☐	☐	☐	☐	☐
Bleeding	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐

Review of Systems – *Please check if you are **currently** experiencing any of the following or check "None"*:

- ☐ Fever / Chills
- ☐ Night Sweats
- ☐ Depression
- ☐ Anxiety
- ☐ Nose Bleeds
- ☐ Blurred Vision
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Nausea / Vomiting
- ☐ Heartburn
- ☐ Urinary Incontinence
- ☐ Frequent Urination
- ☐ Joint Swelling
- ☐ Joint Pains
- ☐ Unsteady Gait
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Rash
- ☐ Poor Healing Wounds
- ☐ Easy Bleeding/Bruising
- ☐ Chronic Infection
- ☐ Excessive Thirst or Urination
- ☐ **None**

Alerts - *Please check all that apply*:

- ☐ History of Blood Clot(s) (DVT)
- ☐ Pregnancy or Planning a Pregnancy
- ☐ Blood Thinners
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Resides in a Skilled Nursing Facility
- ☐ Allergy to Shellfish/Iodine
- ☐ Allergy to Latex
- ☐ Seeing a Pain Management Specialist
- ☐ Metal Allergy
- ☐ Tobacco Usage

Height (in inches): _____ **Weight**: _____ lbs.
(be honest as medical decisions may be made with this information such as prescription dosages).

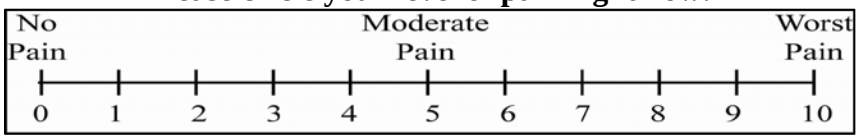
Please inform the provider or orthopedic assistant of any other medical conditions or concerns

ADDITIONAL PATIENT INFORMATION

Patient Name: _____ **Date of Birth**:_____/_____/_____

Doctor or PA that you are seeing today:_____ **Today's Date:** ____/_____/_____

Please circle your level of pain right now:



Do you have a Living Will (Advance Directive)? ☐ No ☐ Yes If Yes, please name responsible person below:

_____

Have you ever received an influenza vaccine?

☐ No (please state reason why)_____

☐ Yes - Date last received:_____

Have you ever received a pneumonia vaccine? ☐ No ☐ Yes