Bone Docs New Patient Intake Form

NAME: _____ DATE OF BIRTH: _____

EMAIL ADDRESS (or parent/guardian's email address): _____

BEST PHONE NUMBER TO REACH YOU: _____ OTHER PHONE NUMBER: _____

HOW DID YOU HEAR ABOUT BONE DOCS/ WHO REFERED YOU: _____

YOUR INJURY / WHAT HURTS: _____

DATE OF INJURY / HOW LONG HAS IT HURT: _____

HEIGHT _____ WEIGHT _____

SMOKING HISTORY: YES or NO ____ppd ALCOHOL: YES or NO ____ drinks per day

MEDICATIONS (Please List Dose): NO MEDICATIONS: ____

_____ _____

_____ _____

_____ _____

ALLERGIES TO MEDICATION (Please List Reaction): NO KNOWN DRUG ALLERGIES: ____

_____ _____

_____ _____

PAST MEDICAL HISTORY:

HEART ATTACK / MI	**ASTHMA**	**DIABETES**	**CANCER (TYPE):_____**	
HYPERTENSION / HTN	**ARTHRITIS**	**SEIZURES**	**LUNG DISEASE / COPD / EMPHSEMA**	
KIDNEY / RENAL DISEASE	**REFLUX/ULCERS**	**DVT / BLOOD CLOTS**	**GOUT**	**HEART FAILURE**
THYROID/HYPOTHYROID	**TUBERCULOSIS / TB**	**HEPATITIS / LIVER**	**HIV**	**SLEEP APNEA**

OTHER: _____

SIGNATURE: _____ DATE:_____

PAST SURGERIES: _____

_____

REVIEW OF SYSTEMS:

General: NONE Fevers/Chills Fatigue Weight Loss/Gain Intentional Weight Loss
Dizziness Headaches Loss Of Consciousness

Neurologic: NONE Loss Of Balance Weakness Clumsiness Numbness/Tingling Tremors

Cardiac: NONE Chest Pain Palpitations Fainting Murmurs

Pulmonary: NONE Shortness Of Breath Cough Wheezing Snoring

GI: NONE Nausea/Vomiting Abdominal Pain Diarrhea Bloody/Tarry Stool

GU: NONE Painful/Difficult/Frequent/Bloody Urination Flank Pain Kidney Stones

Heme: NONE Excessive Bruising Easy/Excessive/Prolonged Bleeding

Skin: NONE Rash Itching Redness Skin Changes Masses/Bumps

Psychiatric: NONE Anxiety Depression Nervousness

Eyes: NONE Blurry/Double/Cloudy Vision Eye Pain Contact Lenses/Glasses

ENT: NONE Hearing Loss Ringing In Ears Ear Pain Sore Throat Difficulty Swallowing

Endocrine: NONE Excessive Thirst/Urination Heat/Cold Intolerance

EMERGENCY CONTACT INFORMATION:

NAME OF CONTACT: _____

RELATIONSHIP:_____

CONTACT PHONE NUMBER:_____

SIGNATURE:_____ **DATE:** _____