**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: \_\_\_\_**

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**ALLERGIES TO MEDICATION (Please List Reaction): NO KNOWN DRUG ALLERGIES: \_\_\_\_**

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**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**