**New Patient/New Problem History Intake Form** *(v. 1/2010)* *Southern Orthopaedic Surgeons, llc*

## PAST MEDICAL HISTORY

*Please check if **you** have **ever** had any of the following or check none:*

❒ NONE

❒ Diabetes ❒ Blood Clots/DVT/PE ❒ Osteoporosis ❒ Asthma ❒ Kidney Disease ❒ Anxiety
❒ Heart Disease/CAD ❒ Staph Infection/MRSA ❒ Rheum. Arthritis ❒ Hepatitis ❒ Liver Disease ❒ Depression
❒ High Blood Pressure ❒ Emphysema/COPD ❒ Lupus/SLE ❒ HIV/AIDS ❒ Pneumonia ❒ Bipolar
❒ Stroke/CVA/TIA ❒ Peptic Ulcer Disease ❒ Fibromyalgia ❒ TB ❒ Sleep Apnea ❒ Chronic Pain
Other:

## PAST SURGICAL HISTORY

*Please check if **you** have **ever** had any of the following or check none:*

❒ NONE

❒ Arthroscopy ❒ Heart Catheterization ❒ Hysterectomy ❒ Hernia Repair ❒ Cancer Surgery
❒ Total Joint ❒ Heart Bypass ❒ Gastric Bypass ❒ Tonsillectomy ❒ Vasectomy
❒ Carpal Tunnel ❒ Pacemaker ❒ Back/Neck Surgery ❒ Rotator Cuff ❒ Tubal Ligation
Other:

## CURRENT MEDICATIONS

*Please list the medications **you** are **currently** taking, check none or other options:*

❒ NONE ❒ SEE ATTACHED LIST ❒ SEE REVERSE FOR ADDITIONAL MEDS

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## DRUG ALLERGIES

*Please list the drug allergies that **you** have/had, check none or other options:*

❒ NONE KNOWN ❒ SEE ATTACHED LIST ❒ SEE REVERSE FOR MORE ALLERGIES

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## SOCIAL HISTORY

*Please answer the following questions about **you**:*

TOBACCO USE: ❒ None ❒ Daily ❒ Occasional
ALCOHOL USE: ❒ None ❒ Daily ❒ Occasional
DRUG ABUSE: ❒ None ❒ Current ❒ Past

EMPLOYED? ❒ No ❒ Yes, position: _____
STUDENT? ❒ No ❒ Yes, school: _____
MARITAL STATUS? ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Child

HOME STATUS: I live with: ❒ Mom, ❒ Dad, ❒ Siblings, ❒ Spouse, ❒ Partner, ❒ Children, ❒ Roommate, ❒ None, I live alone
I live in a: ❒ house, ❒ apartment, ❒ mobile home, ❒ assisted living facility, ❒ nursing home, ❒ shelter, ❒ homeless

## REVIEW OF SYSTEMS

*Please check if **you** currently have or recently had any of the following:*

Gen: ❒ Fever ❒ Chills ❒ Sweats ❒ Weight Loss ❒ Fatigue
Eyes: ❒ Glasses/Contacts ❒ Blind ❒ Blurred ❒ Itching
CV: ❒ Chest Pain ❒ Irregular Heart Beat ❒ Swollen Ankles
Pulm: ❒ Cough/Sneeze ❒ Wheezing ❒ Shortness of Breath
GI: ❒ Constipation ❒ Diarrhea ❒ Bloody/black Stools
MS: ❒ Weakness ❒ Gait Problem ❒ Brace ❒ Aches
❒ Cane ❒ Walker ❒ Wheelchair ❒ Bed rest

GU: ❒ Problems voiding ❒ UTI/burning ❒ Heavy Menstruation
ENT: ❒ Hearing Loss ❒ Ringing ❒ Runny Nose ❒ Sore Throat
Skin: ❒ Rash ❒ Burn ❒ Itching ❒ Dry Skin ❒ Keloid
Neuro: ❒ Dizzy ❒ Tingling ❒ Burning ❒ Numb ❒ Lost Balance
Psych: ❒ Anxious ❒ Depression ❒ Suicidal Thoughts ❒ Rage
Endo: ❒ Hot Flashes ❒ Cold Flashes ❒ Hormone imbalance
Heme: ❒ Free Bleeding ❒ Bruise Easily ❒ Lymphedema

## FAMILY HISTORY

*Does anyone in your immediate **family** have or ever had any of the following:*

❒ Diabetes ❒ Heart Disease ❒ High Blood Pressure ❒ Stroke/CVA/TIA ❒ DVT/PE ❒ Cancer ❒ TB ❒ HIV/AIDS ❒ Hepatitis

*please do not write below this line -- for office use only*

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|---|---|---|---|---|---|---|---|
| bpm | bpm | bpm | bpm | bpm | bpm | bpm | bpm |
| mm Hg | mm Hg | mm Hg | mm Hg | mm Hg | mm Hg | mm Hg | mm Hg |
| lbs | lbs | lbs | lbs | lbs | lbs | lbs | lbs |
| MD | MD | MD | MD | MD | MD | MD | MD |