ORTHOPEDICS
SUMMIT MEDICAL GROUP

PATIENT INTAKE INFORMATION

Today's Date: ____/____/____

Name: ______________________ Age: _______ Date of Birth: ____/____/____

Why are you seeing the doctor today? ______________________

Check: ☐ Right ☐ Left

When did the injury happen? ______________________

How did the injury happen? ______________________

Accident? ☐ No ☐ Yes Type: ☐ Auto ☐ Work ☐ Other: __________

Referring Physician: ______________________ ☐ Check if none

Primary Physician: ______________________ ☐ Check if none

Have you had X-rays taken (for this problem)? ☐ No ☐ Yes When/where: __________

Have you had an MRI (for this problem)? ☐ No ☐ Yes When/where: __________

Medical History:

☐ Cancer	☐ Hypertension/Heart Disease	☐ Ulcers
☐ Anxiety/Depression	☐ Stroke/Vascular Disease/Blood Clot	☐ Diabetes
☐ Acute Infections	☐ Asthma/Other Breathing Problems	☐ Arthritis/Gout
☐ Bleeding Tendency	☐ Convulsions/Seizures	☐ None Apply

Current medications (including over-the-counter), including dosage and frequency: __________

____

______________________________________ ☐ Check if none

Allergies (medications, environmental, latex): ______________________

______________________________________ ☐ Check if none

Past surgical history? ☐ No ☐ Yes If yes, please list surgery & dates of surgery: __________

____

Family history (list any conditions that run in your family and which family member): __________

____

____

Pharmacy name & address (for temporary medications): ______________________

______________________ Phone: (____)______-______ Fax: (____)______-______

PLEASE TURN AND COMPLETE PAGE 2!

PATIENT INTAKE INFORMATION

Name: ______________________________

Social History:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation: ____

Do you consume alcoholic beverages? ☐ No ☐ Yes ______(quantity) ☐ Daily ☐ Weekly ☐ Monthly

Smoking currently? ☐ No ☐ Yes ______ packs for ______ years.

Previously smoked ________ packs per day for ________ years. Quit _______ years ago.

Review of Systems:

Are you currently having or have you had problems with: *(Describe yes responses)*

History of fractures	☐ No	☐ Yes	______________________________
Eyes, blurring of vision, recent change in eyesight	☐ No	☐ Yes	______________________________
Ears, nose, or throat problems	☐ No	☐ Yes	______________________________
Skin rashes or related skin conditions	☐ No	☐ Yes	______________________________
Persistent fever, chills, or night sweats	☐ No	☐ Yes	______________________________
Digestive or bowel problems	☐ No	☐ Yes	______________________________
Frequent urination, or painful or bloody urination	☐ No	☐ Yes	______________________________
Recent gain or loss of more than 10 pounds	☐ No	☐ Yes	______________________________

Vital Signs: (Office Use Only)

Height: __________________ Weight: ______________________ Temperature: _______________________

Patient's Signature: ____ Date: ______/______/______

Physician’s Signature: ____ Date: ______/______/______