Teton Orthopaedics
Patient Intake Form

Today's Date:________________

Patient Name:____
Date of Birth_____________________ Age________________ Height:_____________ Weight:_____________
Ethnicity: Please check Hispanic or Latino Not Hispanic or Latino
Primary Language: English Spanish Other________________ Do you need an interpreter?_______________
Occupation: ________________________________ Referred By: ____
Is this an injury? Yes No Date of Injury:____________ How did the injury occur? _________________________
Is the injury work related? Yes No Dominant Hand: Right Left
Have you had X-rays, MRI, CT or other tests for this problem? Yes No
Do you have images/imaging reports with you? Yes No N/A
Did you have images/imaging reports sent here? Yes No N/A

Chief Complaint:

Body Part & Reason for today's visit:____ Right Left Both

When did it start?____________________________ Pain 0 – 10__________

Are you experiencing any of the following: Please check all that apply:

Pain Swelling Redness Bruising Limited Motion Muscle Weakness Popping

Locking/Catching Stiffness Numbness/Tingling

Have you been treated for this problem before? Yes No

What kind of treatment? Please check:

Medication Injection Splint/Brace PT/OT Surgery Other_______________________________________

Describe treatment: ____

Medications:

Medications/Supplements/Herbs/Vitamins/OTC medicines currently taking:

____
____

Allergies (please list reaction if known): I have no known allergies

____

Review of Systems: *What are you experiencing today?* If none apply check here

Abdominal Pain	Fatigue	Night Sweats
Allergies: Food/Seasonal	Fever	Weight Gain
Anxiety	Frequent Urination	Weight Loss
Asthma	Headache	Seizures
Blurred Vision	Hearing Loss	Skin Infections
Chest Pain	Heartburn	Tremors
Cold Intolerance	Heart Murmur	Vertigo
Cough	Heat Intolerance	Vomiting
Depression	Insomnia	Weakness
Diarrhea	Memory Loss	Other_________________________
Difficulty Urinating	Nausea	______________________________

Physician Notes:

Please continue on other side#

Past Medical History: *Please check all that apply.* If none apply, check here

- Anemia
- Arthritis
- Asthma
- Atrial Fibrillation
- Autoimmune Disorder
- Blood Clot
- Cancer (type)_________
- Congestive Heart Failure
- COPD
- Coronary Artery Disease
- Degenerative Joint Disease
- Depression
- Diabetes (type)_______
- Dementia
- Fibromyalgia
- Gallbladder Disease
- GERD
- Gout
- Headache/Migraine
- Heart Attack
- Hepatitis/Liver Disease
- Hyperlipidemia
- Hypertension
- Inflammatory Bowel Disease
- Kidney Disease
- Lyme Disease
- Mental Illness _________________
- Multiple Sclerosis
- Neurological Disorder_________
- Obesity
- Osteoporosis
- Parkinson's Disease
- Peptic Ulcer Disease
- Prostate Enlargement
- Psoriasis
- Scoliosis
- Seizure Disorder
- Sleep Apnea
- Spinal Stenosis
- Stroke
- Thyroid Disease

Other:_________________________
____

Previous Surgery(s), Include Dates If none apply, check here

- Abdominal Surgery
- Amputation
- Angioplasty
- Appendectomy
- Arthroscopy Ankle
- Arthroscopy Elbow
- Arthroscopy Hip
- Arthroscopy Knee
- Arthroscopy Shoulder
- Arthroscopy Wrist
- Back Surgery
- Cataract Surgery
- Colon Surgery
- Colonoscopy
- Heart Surgery
- Hernia Repair
- Hip Replacement
- Knee Replacement
- LASIK
- Rotator Cuff Repair
- Shoulder Replacement
- Thyroidectomy
- Tonsillectomy

Other:_________________________
____

Family History: *Does anyone in your family have any of the following?* If none apply, check here

- Allergy to Anesthesia
- Asthma
- Blood Clots
- Cancer
- Congestive Heart Failure
- Depression
- Diabetes
- Drug/Substance Abuse
- Epilepsy
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Kidney Disease
- Osteoporosis
- Stroke
- Thyroid Disease

Other:_________________________
____
____

Tobacco/Alcohol Use:

Do you smoke/chew tobacco? Never Current Former Year Quit_______
If yes, how much? ___________ How many years_________________

Do you drink alcohol? Yes No
Frequency ___________________ Amount______________________

Have you ever had a substance abuse problem? Yes No
If **yes**, please specify____

Please describe your physical activity:

- Hiking
- Bike
- Skiing
- Golf
- Tennis
- Walking
- Yoga
- Other

Form filled out by: Patient Parent/Guardian Significant Other Other

Information entered into EMR
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Signature____