Bellevue Bone and Joint Physicians
New Patient Intake Form

Patient to complete information below

Name:_____**DOB**_____**Age**_____ ☐ **Male** ☐ **Female**

Chief Complaint:_____

Body Part:_____ ☐**Right** ☐ **Left** ☐**Both**

When did this problem begin (date of injury):_____

How did it happen: _____

Referring Physician_____FAX_____
Address _____ Phone _____

Primary Care Physician_____FAX _____
Address _____ Phone_____

Pharmacy_____

Occupation_____

Work status? Employed Unemployed Disable Student Retired Homemaker

Is this a work related problem? Yes___ No___ If yes, list your OWCP or L&I #_____
If disabled, when did you last work? _____

- Circle the symptom or symptoms that best describe your problem:

  Stiffness Pain Instability Numbness Swelling Other_____

- If you have pain, please circle the description that is most appropriate:
  Sharp Throbbing Aching Burning Stabbing Heavy dull

- Circle the number corresponding to the intensity of your pain:
  (O = no pain and 10 = the worst pain imaginable) 0 1 2 3 4 5 6 7 8 9 10

- Are your symptoms getting: Better Gradually, Better Rapidly, Worse Gradually, Worse Rapidly

- What improves your symptoms? (Circle all that apply) Rest Ice Heat NSAID
  Other_____

- What makes your symptoms worse?(Circle all that apply) Activity cold pressure
  Other_____

- What studies have you had for this problem? (circle all that apply)

  X-rays CT MRI Nerve study (EMG) Arthrogram Bone Scan Surgery

Allergies

circle all that apply

No known Drug Allergies	Erythromycin	Other:_____
Iodine	Penicillin (PCN)	
Sulfa	Latex	

Current Medications: **Dose:** **Times per day:** **Reason you are taking**

1._____
2._____
3._____
4._____
5._____
6._____

Social History

Marital Status?
Single Married Divorced Separated Widowed Domestic partner

Do you have any children?
Yes___ No___ If so how many____children?

Do you smoke?
Yes___ No___ If yes, how much per day?_____How many years have you been smoking?_____

Do you drink alcohol?
Yes___ No___ If yes, how many_____drinks per week?

Have you ever had a drug or alcohol problem?
Yes___ No___

Social History for Minors
School Grade_____

Living with? Mother Father Both Other_____

Sports?_____

Family History

Please circle if any of your family members have had the following

Diabetes	High Blood Pressure	Stroke	Heart attack	Cancer
Depression	Arthritis	Rheumatoid	Gout	Clotting disorder
Kidney disorder	Other_____			

Medical History

☐ Allergies	☐ Anxiety	☐ Asthma	☐ Bipolar
☐ Bleeding/clotting disorder	☐ Cancer	☐ Chronic lung disease	☐ Depression
☐ Congestive heart failure	☐ Diabetes	☐ Coronary artery disease	☐ Heartburn/reflux
☐ Fibromyalgia	☐ Heart attack	☐ Hepatitis ___ (specify type)	☐ High blood pressure
☐ High cholesterol	☐ Neck Fusion	☐ Psoriasis	☐ Rheumatoid Arthritis
☐ Stroke	☐ Thyroid disorder	☐ Sleep disorder	☐ Other _____

Surgical History

Surgeries: (please circle all that applies)	Years
☐ No previous surgeries	
☐ Appendix (appendectomy)	_____
☐ Gall bladder (cholescystectomy)	_____
☐ By-pass/open heart (CABG)	_____
☐ Hernia repair	_____
☐ Hysterectomy	_____
☐ Tonsils removed (tonsillectomy)	_____
☐ C-Section	_____

Other surgeries

Procedure	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Review of Systems

	Yes	No	Comments
General (weight gain/loss, fatigue, insomnia, fever/chills)			
Eyes (glasses/contacts, cataracts, glaucoma)			
Ear/Nose/Throat (sinus trouble, hearing loss)			
Heart (chest pain, high blood pressure, coronary artery disease, irregular heartbeat)			
Lungs (shortness of breath, asthma, lung disease)			
Stomach (heartburn, nausea, diarrhea, hepatitis)			
Muscle / Bones (joint pain, muscle pain, arthritis, fractures, sprains)			
Urinary Tract (painful urinating, kidney stones, prostate)			
Skin (masses, blisters, dermatitis, eczema)			
Neurologic (seizures, numbness/tingling)			
Mental Health (anxiety, depression)			
Endocrine (frequent urination, excessive thirst, diabetes, hypothyroid)			
Hematological (bleeding/clotting problems, anemia, swollen lymph nodes)			
Allergic / Immunologic(HIV/AIDS, hay fever lupus)			

To be completed by staff:

Height:	**Weight:**	**BP:**	**Pulse**	**Temp:**