PIONEERS MEDICAL CENTER
ADVANCED ORTHOPEDICS

Patient Intake and History Form

Please bring back with appointment

Name_____ Date of Birth_____

Occupation_____

Marital status: Single Partner/Married Divorce Widow

Spouse/Partner Name _____

	None	Self	Mother	Father
Anti-Coagulation	O	O	O	O
Alcoholism	O	O	O	O
Arthritis/Lupus	O	O	O	O
Asthma	O	O	O	O
Blood disorder	O	O	O	O
Cancer	O	O	O	O
Cardiac Stent	O	O	O	O
Diabetes	O	O	O	O
DVT's	O	O	O	O
Heart disease	O	O	O	O
High blood pressure	O	O	O	O
Sleep Apnea	O	O	O	O
Stroke	O	O	O	O
Kidney disease	O	O	O	O
Liver disease	O	O	O	O
Mental disorder	O	O	O	O
Depression	O	O	O	O
Seizure disorder	O	O	O	O
Osteoporosis	O	O	O	O
Thyroid disease	O	O	O	O

Tobacco use Yes/No How long _____ How much_____ Vaping Chew

Drink Yes/No How many per week _____ Whiskey/Beer/ Wine

Recreational/Illegal Drugs Yes/ No What and how long?_____

Allergies:

List of known allergies (including medication allergies) and reaction to allergen.

Or check on of the box: **O No Known Allergies**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

_____ _____

Orthopedic / General Surgeries / Bone Density

List Surgeries and year

_____ _____
_____ _____

_____ _____
_____ _____

Medications: Please include vitamins and supplements

Name Dose, # of times per day

_____ _____
_____ _____
_____ _____
_____ _____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Pharmacy:_____

Mail Order Pharmacy:_____

Primary Physicians Phone number and address:

_____ _____
_____ _____
_____ _____
_____ _____