Nicholas P. Souder, MD
Orthopaedic Surgeon

New Patient Intake Form

Name _____ DOB_____ Date _____

Doctor that referred you or PCP _____

Height _____ Weight _____ Right / Left

Any problems wearing jewelry? Yes / No Pharmacy_____

PRESENT HISTORY

What brings you in today? _____

When did it start? _____

Any injury/trauma? _____

What type of symptoms do you have (pain, catching, giving way, weakness, numbness)? _____

_____

Have you ever had problems before? _____

Anything relieve or make worse? _____

How bad is it on a scale of 1 to 10? _____

Have you had any imaging taken anywhere? _____

SOCIAL HISTORY

Age _____ Occupation _____

Number of children _____ Number of people at home _____

Do you: Use tobacco Yes ___ No ___ Use Alcohol Yes ___ No ___ Use other drugs Yes ___ No ___

How much? _____

If you have in the past, when did you quit? _____

Do you have any religious/cultural practices we should be aware of? Yes ___ No ___

Describe, if yes _____

PAST HISTORY Have you ever had (Yes or No):

High Blood Pressure	Yes No	Diabetes	Yes No	Hepatitis	Yes No
Lung or respiratory problems	Yes No	Stroke	Yes No	HIV / AIDS	Yes No
Bleeding problems	Yes No	Heart Trouble	Yes No	Blood transfusion	Yes No
Cancer	Yes No	Kidney failure	Yes No	Vascular blockage	Yes No

Other: _____

What operations have you had? Please list approximate dates. _____

_____

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New Patient Intake Form Continued

MEDICATIONS: Including name, dosage, over-the-counter, vitamins and herbals.

_____ _____

_____ _____

_____ _____

_____ _____

Do you take aspirin or any other blood thinner? _____

ALLERGIES: List all allergies you are aware of and any symptoms you experience. _____

_____

☐ I have no allergies that I am aware of

FAMILY HISTORY

Have any blood relatives ever had the following: (Yes or No)

Diabetes _____ Relation _____

Heart trouble _____ Relation _____

Type _____

Cancer _____ Relation _____

Sickle cell disease or trait _____ Relation _____

Bleeding problems _____ Relation _____

Problems during surgery or anesthesia _____ Relation _____

GENERAL REVIEW

Have you recently had any of the following:

☐ Fevers or Chills	☐ Shortness of breath	☐ Chest pain
☐ Weight loss or gain	☐ Abdominal pain, nausea, vomiting	☐ Numbness/tingling
☐ Dental problems	☐ Pain or burning with urination	☐ Skin lesions/sores

Patient Signature _____ Physician Signature_____