Andreas M. Sauerbrey, MD

Patient Intake Form

Patient Name_____Date_____
Age_____ Sex_____ Social Security Number_____ Date of Birth_____
What is your Orthopaedic problem? _____Date of Injury_____
Who referred you? _____ Who is your primary care doctor? _____

Past Medical History:
Have you had any medical problems? None ☐

High Blood Pressure	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Gastritis/ulcers	Yes	No
Asthma/emphysema	Yes	No
Diabetes	Yes	No
Thyroid Disease	Yes	No

Other _____
_____

Past Surgical history:
Please list any operations you have had
None ☐

_____ date _____outcome _____
_____ date _____outcome _____
_____ date _____outcome _____

Medications:
Please list all medications you are currently taking
None ☐

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies:
List all drugs to which you are allergic
No known allergies ☐

_____ reaction_____
_____ reaction_____
_____ reaction_____

_____ date _____outcome _____
_____ date _____outcome _____
_____ date _____outcome _____

Social History
Do you use?
Tobacco Yes No Packs/day _____
Alcohol Yes No How much _____
Do you have or have you had a
Problem with chemical dependency Yes No
Employer _____ How long _____
Occupation _____ Hobbies_____

Family History
Has anybody in your family had any of these conditions?
Heart disease Yes No
Stroke Yes No
Cancer Yes No
Other _____

Review of systems
Do you have any of these symptoms? Please circle either Yes or No for each condition.

Constitutional			**Eyes**			**Ear, Nose and Throat**		
Weight loss/gain	Yes	No	Decreased vision	Yes	No	Loss of Hearing	Yes	No
Fever	Yes	No	Cataracts	Yes	No	Sinus problems	Yes	No
Heart			**Lungs**			**Gastrointestinal**		
Chest pain	Yes	No	Shortness of breath	Yes	No	Stomach pain	Yes	No
Irregular heart beat	Yes	No	Wheezing	Yes	No	Diarrhea	Yes	No
Poor circulation	Yes	No	Persistent cough	Yes	No	Persistent vomiting	Yes	No
Genitourinary			**Musculoskeletal**			**Skin**		
Bloody urine	Yes	No	Joint swelling	Yes	No	Rash	Yes	No
Pain on urinating	Yes	No	Muscle aches	Yes	No	Dryness of skin	Yes	No
Unable to urinate	Yes	No	Joint pain	Yes	No			
Neurological			**Psychiatric**			**Endocrine**		
Paralysis	Yes	No	Depression	Yes	No	Thyroid problems	Yes	No
Frequent headaches	Yes	No	Bipolar disease	Yes	No	Diabetes	Yes	No
Blood			**Allergic**					
Bleeding problems	Yes	No	Allergies to foods	Yes	No	Reviewed By:		
Blood transfusion	Yes	No	Allergies to adhesive,			Initials _____ Date _____		
Blood clots	Yes	No	dye, or iodine	Yes	No	Initials _____ Date _____		