SHAWS COVE ORTHOPÆDICS

Jeffrey A. Miller, D.O.
Board Certified Orthopaedic Surgeon

Patient Intake Form

Name: _____ Age: _____ D.O.B. _____

Reason for visit: _____ Injury Date: _____

Primary Care Physician: _____ R L Handed

Height: _____ Weight: _____

Past Medical History (circle YES or NO):

Y N Asthma	Y N High Blood Pressure	Y N Diabetes
Y N Anemia	Y N Heart Attack	Y N Heartburn
Y N Cancer	Y N Stroke	Y N Kidney Disease
Y N COPD	Y N Thyroid Disorder	Y N Liver Disease

Have you had Surgery before? Explain: _____

What Medications do you take everyday? _____

What Pharmacy do you use? _____

Are you allergic to any meds? _____

Y N Weight loss	Y N Shortness of breath	Y N Rashes
Y N Weight gain	Y N Vomiting / diarrhea	Y N Headache
Y N Wear glasses	Y N Urinary problems	Y N Dizziness
Y N Hearing loss	Y N Sore muscles	Y N Chest pain

Do you have any implants? (pace maker, total joints, metal) _____

Please list medical problems of family members: _____

Tobacco Y N How much? _____ Alcohol Y N How much? _____

Signature of Patient: _____ Date: _____

Signature of Provider: _____ Date: _____

Requests for Prescription Refills must be made Mon–Thurs /No scrips are called in Fri/Sat/Sun
