New Patient Intake Form - History of Present Illness

Date: _____ Name: _____

Date of Birth: _____ □ Male □ Female □ Other _____

Primary Care Physician: _____
Marital Status: □ Married □ Single □ Widowed □ Divorced □ Life partner
Did your doctor refer you here? □Yes □No Referring Physician: _____
Name of Employer: _____ Occupation: _____
Is this a work related Injury? □Yes □No

Have you had x-rays, MRI, CT or other tests for this problem? □Yes □ No
Do you have them with you? □ Yes □ No
Have you been to the Emergency Room for this problem? □ Yes □ No
If yes: Date seen: _____ Which Emergency Room? _____

Preferred Communication: □Written □ Visual □ Sign Language □ No preference Primary Language: □ English □ Other _____ Interpreter Needed □ Yes □ No Barriers to Learning?_____

Chief Complaint
Reason you are being seen today: _____
Which side of your body is injured: □ Right □ Left □ Bilateral
Where is your pain or problem? _____
When did it start? _____ Is it: □ Sharp □ Burning □ Dull □ Aching □ Throbbing
Is it □ Mild □ Moderate □ Severe
When does it occur? □Morning □Night □Constant □After Exercise □ During Exercise □ Intermittent
Has it: □Improved □Stayed the same □Worsened
Describe what makes it better: _____
Describe what makes it worse: _____
Do you have any of the following: □Swelling □Numbness □Bruising □Tingling

Medications, Supplements, & Vitamins You Currently Take (List dosage and how often)
_____
_____

Medication Allergies (Please also list reaction if known)
_____

Do you smoke? □Yes □ No □Quit If yes, how much? _____ How many years? _____ Do you drink alcohol? □Yes □ No □Quit If yes, how much/often? _____ Do you have a cardiologist? □ Yes □No Who:_____ Are you: □Right Handed □Left Handed □Ambidextrous □Unknown at this time

Continued on Next Page

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Comprehensive History

Review of Systems: What are you experiencing today?

□ Fatigue
□ Fever
□ Night Sweats
□ Weight Gain
□ Weight Loss
□ Difficulty Swallowing
□ Hoarseness
□ Chest Pain
□ Irregular Heart Beat
□ Fainting
□ Leg Ulcers
□ Swelling in hands □ Swelling in feet □ Nausea
□ Previous Blood Clot □ Asthma
□ Vomiting
□ Heartburn
□ Change in bowel habits
□ Constipation
□ Diarrhea
□ GERD
□ Incontinence
□ Bladder Infection
□ Urinary Frequency
□ Urinary Urgency
□ Back Pain
□ Joint Pain
□ Joint Swelling
□ Muscle Aches
□ Hepatitis
□ High Cholesterol
□ Ulcers
□ Skin Infection
□ Joint Infection
□ Muscle Weakness
□ Stiffness
□ Neck Pain
□ Leg Pain
□ Muscle Spasm □ Gout
□ Groin Pain □ Hair Changes □ Changes in Moles
□ Skin Changes □ Itchiness
□ Rash
□ Bruises
□ Bleeding
□ Limping
□ Headache
□ Migraine
□ Numbness
□ Tingling
□ Seizures
□ Slurred Speech
□ Frequent Falls
□ Confusion
□ Dropping Things Frequently
□ Depression
□ Anxiety
□ Mental Illness
□ Anemia
□ Other_____

Past Medical History

□ Hypertension
□ Diabetes
□ Kidney Disease □ Stroke
□ Arthritis
□ Blood Disorders
□ Arrhythmia
□ Osteoporosis
□ Substance Abuse
□ Alcoholism
□ Multiple Sclerosis
□ HIV
□ AIDS
□ Past Blood Transfusions
□ Seizure Disorder
□ Thyroid Disease
□ Coronary Artery Disease
□ Bladder Infections □ MRSA
□ Sleep Apnea/CPAP
□ Cancer(type) _____ □ Mental Illness
□ Gout □ Fractures □ Other:_____

Previous Surgery(s), Include Dates

_____

_____

Family History Does anyone in your family have any of the following? ***Please list relative next to disorder***

□ Diabetes
□ Thyroid Disease □ Asthma
□ High Cholesterol □ High Blood Pressure □ Heart Disease
□ Kidney Disease
□ Stroke
□ Blood Clots
□ Epilepsy/Seizures
□ Congestive Heart Failure □ Alcoholism
□ Depression
□ Substance Abuse
□ Osteoporosis
□ Cancer (type) _____ □ Other: _____

This form was filled out by: □ Patient □ Parent/Guardian □ Significant Other □ Other

Signature: _____

□ Information Entered in EMR