WESTPHAL ORTHOPEDICS

New Patient Intake Form

Patient Name: _____ DOB: ____/_____/_____

Height: _____ Weight (lbs.): _____

Medication Allergies:

Medication	Reaction Type	When (estimate)?

Current Medications:

Name	Dose	Reason for Medication

Turn Over ⇨

Current Medical Problems (Issues you are currently being treated for)

☐ Cardiac ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol

☐ Hypothyroid ☐ Kidney Disease ☐ Obesity ☐ Osteoporosis

☐ Other (Please specify): _____

Past Medical Surgeries	**DATE**
Gastric Bypass	
Heart Stent/Bypass	
Joint Replacement	
Knee Scope	
Pacemaker/Defibrillator	
Rotator Cuff Repair	
Other (Please specify):	

Medical History:

☐ ALS
☐ Anemia
☐ Bleeding Tendency
☐ Blood Clots
☐ Cancer-Type: _____
☐ Clotting Disorder
☐ Colon Problems
☐ Enlarged Prostate
☐ Gout
☐ Heart Attack
☐ Heart Murmur
☐ Hepatitis A, B, C
☐ High Blood Pressure
☐ HIV
☐ Pneumonia
☐ Rheumatoid Arthritis
☐ Stomach Ulcer
☐ Stroke
☐ Other: _____

Have you had previous surgery for your current pain or problem?

☐ **Yes** ☐ **No**

If **YES**: Type of surgery: _____ Date: _____ Surgeon: _____

Did it make your pain: ☐ Better ☐ Worse

Have you ever had any other alternative forms of medical treatment that we should know about?

_____

_____