TULSA BONE & JOINT ASSOCIATES – Jimmy D. Huebert, MD
NEW PATIENT INTAKE FORM

NAME:	**SSN:**	**DOB:** Todays Date:
PRIMARY CARE PHYSICIAN:		
REFERRING PHYSICIAN:		

CHIEF COMPLAINT:

Why you are seeing the doctor today?

Current Medications & Supplements:	**ALLERGIES:**

MEDICAL HISTORY

Current medical problems/conditions:

Hospitalizations & Surgeries:

Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:

Have you or anyone in your family ever had a complication from surgery?

Other conditions/problems your doctor should know about:

FAMILY HISTORY:

Father: diseases		If deceased: what age?
Mother: diseases		If deceased: what age?:
Siblings: diseases		If deceased: what age?:

SOCIAL HISTORY:

Occupation:	Employer
Education Level:	Athlete: yes no

Sports/activities you participate in regularly/weekly:

Tobacco	Chewing: Dips/day:	Smoking: Packs/day:	How many years?	Quit how long ago?
Alcohol	# Drinks/day:		# Drinks/month:	

Have you used or currently using recreational drugs?

REVIEW OF SYSTEMS:

General	Recent changes in ☐ weight ☐ appetite ☐ fevers ☐ night sweats ☐ energy level	
ORTHO	Any broken bones in the past?	Which bones and when:
	Any joint pain, swelling, or deformities?	Which joints?
	Any history of arthritis?	
HEENT	Changes in vision or hearing?	
	Difficulty swallowing or persistent hoarseness?	
	Migraine headaches?	
Neck	Swollen glands or masses?	
	Pain or stiffness?	
Heart & Lungs	Have you ever had a heart attack?	
	Do you or have you experienced: ❑ Chest pain/angina ❑ Shortness of breath ❑ Racing heart/palpitations ❑ Leg/feet swelling ❑ Blood clots – DVT – PE (circle all that apply)	❑ Wheezing ❑ Asthma – Exercise induced asthma (circle all that apply) ❑ Coughing up blood ❑ Coughing
GI/GU	Have you ever experienced: ❑ Black/bloody stools ❑ Reflux – GERD ❑ Bleeding ulcers ❑ Hemorrhoids ❑ Hepatitis A B C other (circle all that apply)	❑ Kidney stones ❑ Stress incontinence ❑ Difficulty with urine flow ❑ Painful urination ❑ Prostate problems
Skin	Changes in moles?	Other skin conditions:
Mood	Have you or are you receiving treatment for or seen a mental healthcare professional for:	
	❑ Depression ❑ Anxiety ❑ Bipolar disorder	❑ Chronic pain problems ❑ Suicidal thoughts ❑ Seasonal Affective Disorder
Neuro	Have you or do experience:	
	❑ Seizures ❑ Memory loss ❑ Unexplained weakness	❑ Tremors ❑ Dizziness ❑ Stroke/TIA
Other	Do you have any health problems or concerns that your doctor should know about?	

FOR WOMEN ONLY

OB/GYN	Last PAP:	Last period:	Are your cycles regular?
	Regular self breast exams?		
	Have you gone thru menopause?		How long ago?
	Are you or could you be pregnant now? ☐ Yes ☐ No		