rebound
ORTHOPEDICS & NEUROSURGERY
The Region's Most Preferred.

Annual Intake Form

PATIENT INFORMATION

First Name________________________ MI___ Last Name____________________________ Birth Date_________

Sex _____________ Height ______________ Weight ________________

Home Phone_(_____)________________ Mobile Phone_(_____)___________________

Address____

Email____ Employer/Occupation ___________________________

Emergency Contact_______________________ Relation____________ Contact number_(_____)_____________

Primary Care Physician_____________________________ Primary Care Clinic______________________________

REFERRAL INFORMATION

Did another physician refer you? ☐ Yes ☐ No if so, who? _____________________________________

If not, how did you hear about us? ☐ Family/Friend ☐ Yelp ☐ Google ☐Other_____________________

ALLERGIES & MEDICATIONS

Are you allergic to any of the following?

☐Penicillin, Reaction:_____________ ☐ Sulfa Drugs, Reaction:_____________ ☐ Antibiotics, Reaction:__________
☐ Pain Meds, Reaction:_____________ ☐ Latex, Reaction:______________ ☐ Anesthesia, Reaction:____________
☐ Eggs/chicken, Reaction:_______________ ☐ Metals, Reaction:_______________ ☐ Other:

Allergy:_______________, Reaction:_______________ Allergy:_______________, Reaction:_______________

Allergy:_______________, Reaction:_______________ Allergy:_______________, Reaction:_______________

Medication List Please list all medications you are currently taking (names & dosages, if known) – If you have a list, let us know and we will make a copy

Name of Medication	Dose	Name of Medication	Dose

PREFERRED PHARMACY

Pharmacy name_______________________________

Pharmacy Address (or city)____

SOCIAL HISTORY

Tobacco Use: ☐ Yes ☐ No ☐ Quit, when? ____________

If yes or quit, how many years did or have you smoked: __________________

About how many packs a day?: ____________ If smokeless, how much?: _______________

Vape Use: ☐ Yes ☐ No ☐ Quit, when? ____________

Alcohol Use: ☐ Yes ☐ No; If yes, how much and how often?: ____________________________

Drug Use: ☐ Yes ☐ No, If yes, what kind?: __________________________________

Hand Dominance? ☐ Right ☐ Left

IMMUNIZATIONS

Influenza ☐ No ☐ Yes, date:_________

Pneumococcal ☐ No ☐ Yes, date: __________

REVIEW OF SYSTEMS

Please **mark** any symptoms you are experiencing currently:

Cardiorespiratory	Yes	No
Chest pain	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐

Neurological	Yes	No
Muscle Weakness	☐	☐
Dizziness	☐	☐
Frequent falls	☐	☐
Blurred vision	☐	☐

Gastrointestinal	Yes	No
Abdominal pain	☐	☐
Heartburn	☐	☐

Urinary	Yes	No
Frequent urination	☐	☐
Urinary incontinence	☐	☐

Ortho	Yes	No
Joint swelling	☐	☐

Other	Yes	No
Skin rash	☐	☐

General	Yes	No
Fever or chills	☐	☐
Nausea/vomiting	☐	☐
Excessive bleeding	☐	☐
Excessive bruising	☐	☐
Mood changes	☐	☐
Unexplained weight loss	☐	☐

HEALTH CONDITIONS

Do you have any of the following health conditions?

☐ High Blood Pressure ☐ Hepatitis B or C ☐ Bleeding Disorder ☐ Blood Clots

☐ Anemia ☐ Sleep Apnea ☐ Seizure ☐ Polio Syndrome
☐ Heart Disease ☐ Atrial Fibrillation ☐ Pulmonary Embolism ☐ Kidney Disease
☐ Rheumatoid Arthritis ☐ MRSA ☐ Osteoporosis ☐ Hypothyroidism
☐ HIV ☐ Pace Maker ☐ Gout

☐ Diabetes (circle one) Type 1 or Type 2

Other

____

____

PAST SURGICAL HISTORY
Please list any relevant past surgeries and the approximate date

Surgery (please include side if applicable**)**	**Date**
____	_______________
____	_______________
____	_______________
____	_______________
____	_______________
____	_______________
____	_______________

FALL SCREENING
Have you had any falls in the last year? ☐ No ☐ Yes
If Yes, how many falls? _________________ Did the fall result in an injury? ☐ No ☐ Yes

DEXA Bone Scan
Have you had a DEXA Bone Scan? ☐ No ☐ Yes
If Yes, approximately what date? _________________

CONSENTS

Would you like to opt in for text message appointment reminders? ☐ Yes ☐ No

May we leave a detailed phone message? ☐ Yes ☐ No

Is there anyone else you would like to approve Rebound to speak to on your behalf? ☐ Yes ☐ No,

Full Name________________________ Relationship______________________

OFFICE USE ONLY

MRN____________________ Date Completed______________ Registrar_________________________________