Kyle J. Moyles, M.D., M.B.A.
Orthopaedic Hand Surgeon

Patient Intake Form

Name: ______________ Date of Birth: ______________ Primary Doctor: ______________

Occupation: ______________ Working Status: ______________ Work Related Injury: Yes / No

Chief Complaint (Why are you here?): ______________

Medications: ______________

____

Pharmacy Name and Location: ______________

Allergies with Reactions: ______________

Review of Systems (Are you currently having or have you had problems with your):

	Circle		Describe Your Answer
Heart, Stroke, High BP	No	Yes	
Lungs, Breathing, Asthma	No	Yes	
Diabetes, Thyroid Disorder	No	Yes	
Bleeding Problems	No	Yes	
HIV / AIDS	No	Yes	
Cancer	No	Yes	
Skin	No	Yes	
Digestion, Ulcer, Acid Reflux	No	Yes	
Arthritis, Gout	No	Yes	

OTHER PROBLEMS? ______________

Past Surgery (Year & Type): ______________

____

Height: ______ Weight: ______ Pulse Ox: ______ Do you smoke? Yes / No Packs per Day ______ # of Yrs ______

Any Family Illness (Heart Attacks, Cancer, Rheumatoid Arthritis, etc)? ______________

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Who Referred you to us? ______________

Patient Signature: ______________ Date: ______________

Reviewed By: ______________ M.D. Date: ______________