



ORTHOPEDIC CENTERS OF COLORADO

PATIENT INTAKE AND HISTORY FORM

Today's Date: _____

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Tel: _____

Primary Care Physician City: _____ ZIP: _____

Referral Source: _____ Tel: _____

Have you been treated at any Orthopedic Centers of Colorado division in the last 3 years?

- Advanced Orthopedic Cornerstone Orthopaedics Orthopedic Associates
 CCOE Denver Spine Specialists Peak Orthopedics
 Colorado Orthopedic Consultants Hand Surgery Associates

Local Pharmacy: _____
(Name/City/Phone #)

Mail Order Pharmacy: _____
(Name/City/Phone #)

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for Today's Visit: _____

Hand Dominance: Left Hand Right Hand Ambidextrous **Shoe Size:** _____

How did the problem start? Gradual Suddenly Exacerbation of an old injury/issue

When did the problem start? _____hour(s) ago _____day(s) ago _____week(s) ago _____month(s) ago

Where did the injury take place? at home at work at school while playing sports while playing
 during recreational activities in a motor vehicle accident

Please describe the progression of the problem: unchanged fluctuating resolved stable
 improving worsening

Describe the severity of the symptoms/pain: mild mild to moderate moderate moderate to severe
 interfering with sleep incapacitating

How would you describe your pain? aching a deep ache shooting a burning sensation
 throbbing superficial a discomfort a dull ache burning cramping sharp stabbing

How often does your pain occur? intermittently occasionally frequently constantly rarely
 during the day nocturnally

What makes the condition feel worse? _____

What makes the condition feel better? _____

Have you seen another physician for this issue? no yes, when and who? _____

What treatments have you tried in the past? none application of ice application of heat
 physical therapy exercise activity modification a brace NSAID other medication _____
 corticosteroid injections acupuncture chiropractic care other non-surgical treatment: _____
 surgical repair: _____

ALLERGY HISTORY:

None NKDA (No Known Drug Allergies)

Metal Allergies: No Yes (Details/Reaction): _____

Latex Allergies: No Yes (Details/Reaction): _____

Cement Allergies: No Yes (Details/Reaction): _____

Medication Allergies: No Yes (Details/Reaction): _____

Other Allergies: No Yes (Details/Reaction): _____

MEDICATION HISTORY:

I am not currently taking any medications

List any medications, vitamins, minerals, supplements, and alternative/herbal medications that you are currently taking:

<u>Name of Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Reason</u>

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Alzheimer Disease | <input type="checkbox"/> Degenerative Disc Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> IBS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Lupus | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Blood Clots/DVT | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Spondyloarthropathy |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Fracture | <input type="checkbox"/> Heart Attack (MI) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Gout | <input type="checkbox"/> Obesity | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Headache | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson Disease | <input type="checkbox"/> Hist. of Diabetes |
| <input type="checkbox"/> Coronary Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Peptic Ulcer | |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Psoriasis | |
| <input type="checkbox"/> Other: _____ | | | |

Do you have any of the following:

History of Joint Infection? History of Benign Tumor? History of Cancer?

If yes, please give detailed information, including body location and time period:

FAMILY HISTORY:

Place an "X" under the correct family member with the condition and indicate "P" if the family member passed away due to that condition.

	Mother / Father / Sibling				Mother / Father / Sibling		
Alcohol Abuse	_____	_____	_____	Gout	_____	_____	_____
Anemia	_____	_____	_____	Heart Disease	_____	_____	_____
Arthritis	_____	_____	_____	Hypertension	_____	_____	_____
Anesthetic Complications	_____	_____	_____	High Cholesterol	_____	_____	_____
Anxiety	_____	_____	_____	Kidney Disease	_____	_____	_____
Asthma	_____	_____	_____	Lung/Resp Disease	_____	_____	_____
Birth Defects	_____	_____	_____	Migraines	_____	_____	_____
Blood Disorder	_____	_____	_____	Osteoporosis	_____	_____	_____
Cancer _____	_____	_____	_____	Seizure Disorder	_____	_____	_____
Depression	_____	_____	_____	Severe Allergies	_____	_____	_____
Diabetes, Type I	_____	_____	_____	Stroke	_____	_____	_____
Diabetes, Type II	_____	_____	_____	Substance Abuse	_____	_____	_____
Genetic Disease	_____	_____	_____	Thyroid Problems	_____	_____	_____
Other: _____							_____

PAST SURGICAL HISTORY: **None** (Please mark as applicable, date does not need to be exact)

<u>Procedure</u>	<u>Year</u>	<u>Procedure</u>	<u>Year</u>	<u>Procedure</u>	<u>Year</u>
<input type="checkbox"/> ACL Repair – Left	_____	<input type="checkbox"/> Cardiac Bypass Surgery	_____	<input type="checkbox"/> Knee Replacement – Left	_____
<input type="checkbox"/> ACL Repair – Right	_____	<input type="checkbox"/> Cardiac Pacemaker Insertion	_____	<input type="checkbox"/> Knee Replacement – Right	_____
<input type="checkbox"/> Amputation	_____	<input type="checkbox"/> Cardiac Valve Replacement	_____	<input type="checkbox"/> Meniscus – Left	_____
<input type="checkbox"/> Angioplasty	_____	<input type="checkbox"/> Carpal Tunnel Surgery – Left	_____	<input type="checkbox"/> Meniscus – Right	_____
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Carpal Tunnel Surgery – Right	_____	<input type="checkbox"/> ORIF Fracture – Left	_____
<input type="checkbox"/> Arthroscopic Ankle – Left	_____	<input type="checkbox"/> Cataract Surgery	_____	<input type="checkbox"/> ORIF Fracture – Right	_____
<input type="checkbox"/> Arthroscopic Ankle – Right	_____	<input type="checkbox"/> Cholecystectomy/Gallbladder	_____	<input type="checkbox"/> Rotator Cuff Repair – Left	_____
<input type="checkbox"/> Arthroscopic Knee – Left	_____	<input type="checkbox"/> Colectomy	_____	<input type="checkbox"/> Rotator Cuff Repair – Right	_____
<input type="checkbox"/> Arthroscopic Knee – Right	_____	<input type="checkbox"/> Colostomy	_____	<input type="checkbox"/> Small Bowel	_____
<input type="checkbox"/> Arthroscopic Shoulder – Left	_____	<input type="checkbox"/> Gastric Bypass	_____	<input type="checkbox"/> Thyroidectomy	_____
<input type="checkbox"/> Arthroscopic Shoulder – Right	_____	<input type="checkbox"/> Hernia Repair	_____	<input type="checkbox"/> Orthopedic: _____	_____
<input type="checkbox"/> Back Surgery	_____	<input type="checkbox"/> Hip Replacement – Left	_____	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Blood Transfusion	_____	<input type="checkbox"/> Hip Replacement – Right	_____	<input type="checkbox"/> Other: _____	_____

Have you experienced any adverse events associated with surgery or anesthesia?

No **Yes, if so, please give pertinent details:**

SOCIAL HISTORY:

Please describe your current smoking habits:

Never Former

Current: Cigarettes Vaping Marijuana Marijuana Edibles Chew/Dip

Frequency: Current every day Light Occasional Heavy

Do you drink alcoholic beverages? Yes No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? Yes No

If yes, please indicate what type of drug and how often: _____

How would you rate your exercise level? Sedentary Mild Moderate Vigorous

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. Your doctor will discuss any positive responses with you.

General: <input type="checkbox"/> Normal
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Chills
<input type="checkbox"/> Fever
<input type="checkbox"/> Unexplained Weight Loss
<input type="checkbox"/> Unexplained Weight Gain

Cardiovascular: <input type="checkbox"/> Normal
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Fainting
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Murmur

Psychiatric: <input type="checkbox"/> Normal
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Drug/Alcohol Abuse

Skin: <input type="checkbox"/> Normal
<input type="checkbox"/> Blisters
<input type="checkbox"/> Rash
<input type="checkbox"/> Infection or history of MRSA
<input type="checkbox"/> Ulcer

Gastrointestinal: <input type="checkbox"/> Normal
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Heartburn

Endocrine/Glands: <input type="checkbox"/> Normal
<input type="checkbox"/> Unexplained Weight Loss
<input type="checkbox"/> Unexplained Weight Gain
<input type="checkbox"/> Fever
<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Diabetes

HEENT: <input type="checkbox"/> Normal
<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Vision Loss

Neurological: <input type="checkbox"/> Normal
<input type="checkbox"/> Headaches
<input type="checkbox"/> Numbness
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Frequent Falls
<input type="checkbox"/> Fainting
<input type="checkbox"/> Seizures
<input type="checkbox"/> Weakness
<input type="checkbox"/> Tremors
<input type="checkbox"/> Unsteadiness

Hematology: <input type="checkbox"/> Normal
<input type="checkbox"/> Anemia
<input type="checkbox"/> Easy Bleeding
<input type="checkbox"/> Blood Clots

Respiratory: <input type="checkbox"/> Normal
<input type="checkbox"/> Cough
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Recent Respiratory Infection
<input type="checkbox"/> Sleep Apnea

MSK: <input type="checkbox"/> Normal
<input type="checkbox"/> Negative except noted in reason for visit
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Osteoporosis

Name: _____

DOB: _____