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): ______________________________

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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:

Name of Medication	Dose	Frequency	Reason

PROBLEM LIST/PAST MEDICAL HISTORY:

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

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

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____

Name: ____________________________________ DOB: ________________

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.

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

Other:____

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

Procedure	Year	Procedure	Year	Procedure	Year
☐ ACL Repair – Left	________	☐ Cardiac Bypass Surgery	________	☐ Knee Replacement – Left	________
☐ ACL Repair – Right	________	☐ Cardiac Pacemaker Insertion	________	☐ Knee Replacement – Right	________
☐ Amputation	________	☐ Cardiac Valve Replacement	________	☐ Meniscus – Left	________
☐ Angioplasty	________	☐ Carpal Tunnel Surgery – Left	________	☐ Meniscus – Right	________
☐ Appendectomy	________	☐ Carpal Tunnel Surgery – Right	________	☐ ORIF Fracture – Left	________
☐ Arthroscopic Ankle – Left	________	☐ Cataract Surgery	________	☐ ORIF Fracture – Right	________
☐ Arthroscopic Ankle – Right	________	☐ Cholecystectomy/Gallbladder	________	☐ Rotator Cuff Repair – Left	________
☐ Arthroscopic Knee – Left	________	☐ Colectomy	________	☐ Rotator Cuff Repair – Right	________
☐ Arthroscopic Knee – Right	________	☐ Colostomy	________	☐ Small Bowel	________
☐ Arthroscopic Shoulder – Left	________	☐ Gastric Bypass	________	☐ Thyroidectomy	________
☐ Arthroscopic Shoulder – Right	________	☐ Hernia Repair	________	☐ Orthopedic: ___________	________
☐ Back Surgery	________	☐ Hip Replacement – Left	________	☐ Other: _______________	________
☐ Blood Transfusion	________	☐ Hip Replacement – Right	________	☐ Other: _______________	________

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

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

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____

____

Name: ____ DOB: ___________________

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

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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: ☐**Normal**
- ❑ Fatigue
- ❑ Chills
- ❑ Fever
- ❑ Unexplained Weight Loss
- ❑ Unexplained Weight Gain

Skin: ☐**Normal**
- ❑ Blisters
- ❑ Rash
- ❑ Infection or history of MRSA
- ❑ Ulcer

HEENT: ☐**Normal**
- ❑ Blurred Vision
- ❑ Vision Loss

Respiratory: ☐**Normal**
- ❑ Cough
- ❑ Wheezing
- ❑ Shortness of Breath
- ❑ Difficulty Breathing
- ❑ Recent Respiratory Infection
- ❑ Sleep Apnea

Cardiovascular: ☐**Normal**
- ❑ Chest Pain
- ❑ Fainting
- ❑ Dizziness
- ❑ Murmur

Gastrointestinal: ☐**Normal**
- ❑ Nausea
- ❑ Vomiting
- ❑ Stomach Ulcer
- ❑ Heartburn

Neurological: ☐**Normal**
- ❑ Headaches
- ❑ Numbness
- ❑ Dizziness
- ❑ Frequent Falls
- ❑ Fainting
- ❑ Seizures
- ❑ Weakness
- ❑ Tremors
- ❑ Unsteadiness

Psychiatric: ☐**Normal**
- ❑ Anxiety
- ❑ Depression
- ❑ Drug/Alcohol Abuse

Endocrine/Glands: ☐**Normal**
- ❑ Unexplained Weight Loss
- ❑ Unexplained Weight Gain
- ❑ Fever
- ❑ Thyroid Problems
- ❑ Diabetes

Hematology: ☐**Normal**
- ❑ Anemia
- ❑ Easy Bleeding
- ❑ Blood Clots

MSK: ☐**Normal**
- ❑ Negative except noted in reason for visit
- ❑ Arthritis
- ❑ Osteoporosis