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:** __N/A

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 dull ache __a deep ache __shooting __a burning sensation
__throbbing __superficial __a discomfort __stabbing __cramping
__sharp

How often does your pain occur? __intermittently __occasionally __frequently __constantly
__rarely __during the day __nocturnally

What makes your condition feel worse? _____
What makes your condition feel better? _____
Have you seen another physician for this issue? __No __Yes, who and when? _____

_____

What treatments have you tried in the past? __None

__Application of ice __Application of heat __Physical Therapy __Exercise __Activity Modification __Brace
__NSAIDS __Other Medication __Corticosteroid Injections __Acupuncture __Chiropractic care __Surgical Treatment
__Massage __Dry Needling __Non-Surgical Treatment __TENS Unit

ALLERGY HISTORY:

___None **___NKDA (No Known Drug Allergies)**

Metal Allergies: __No __Yes - Agent:_____ Reaction: _____
Latex Allergies: __No __Yes - Agent:_____ Reaction: _____
Cement Allergies: __No __Yes - Agent:_____ Reaction: _____
Medication Allergies: __No __Yes - Agent:_____ Reaction: _____
Agent:_____ Reaction: _____
Agent:_____ Reaction: _____
Agent:_____ Reaction: _____

Other Allergies: __No __Yes - Agent:_____ Reaction:_____
Agent:_____ Reaction:_____
Agent:_____ 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
____Multiple Sclerosis

__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)

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	_____	__ Neck Surgery	_____
__ Arthroscopic Ankle – Left	_____	__ Cataract Surgery	_____	__ ORIF Fracture – Left	_____
__ Arthroscopic Ankle – Right	_____	__ Cholecystectomy/Gallbladder	_____	__ ORIF Fracture – Right	_____
__ Arthroscopic Knee – Left	_____	__ Colectomy	_____	__ Rotator Cuff Repair – Left	_____
__ Arthroscopic Knee – Right	_____	__ Colostomy	_____	__ Rotator Cuff Repair – Right	_____
__ Arthroscopic Shoulder – Left	_____	__ Gastric Bypass	_____	__ Small Bowel	_____
__ Arthroscopic Shoulder – Right	_____	__ Hernia Repair	_____	__ Thyroidectomy	_____
__ Back Surgery	_____	__ Hip Replacement – Left	_____	__ Orthopedic:	_____
__ 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:**

SOCIAL HISTORY:

Please describe your current smoking habits:

__Never __Former (I quit___years ago)

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.

General: ☐Normal
- ❑ Fatigue
- ❑ Chills
- ❑ Difficulty swallowing
- ❑ Peripheral Neuropathy- decreased sensation in extremities

Skin: ☐Normal
- ❑ Blisters
- ❑ Rash
- ❑ Infection or historyof 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
- ❑ Memory Loss
- ❑ Concussion
- ❑ Previous Brain Injury

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
- ❑ Carpal tunnel

ORTHOPEDIC CENTERS OF COLORADO
Denver Spine Surgeons

Gary Ghiselli, MD
Renee Kirchner, PA-C
Brooke Distefano, PA-C

Sanjay Jatana, MD
Heather Duncan, PA-C

David Wong, MD
Chelsea Burg, PA-C

For office use only:
Room:_____
Computer:_____

Today's Date:_____ Name:_____ DOB:_____Age:_____

Height:_____ft_____inches Weight:_____lbs (for office use only: BP:_____/_____Pulse ox:_____Temp:_____F)

Have you had imaging for this problem? YES NO (XRAYS MRI CT OTHER:_____)
If so, where and when?_____

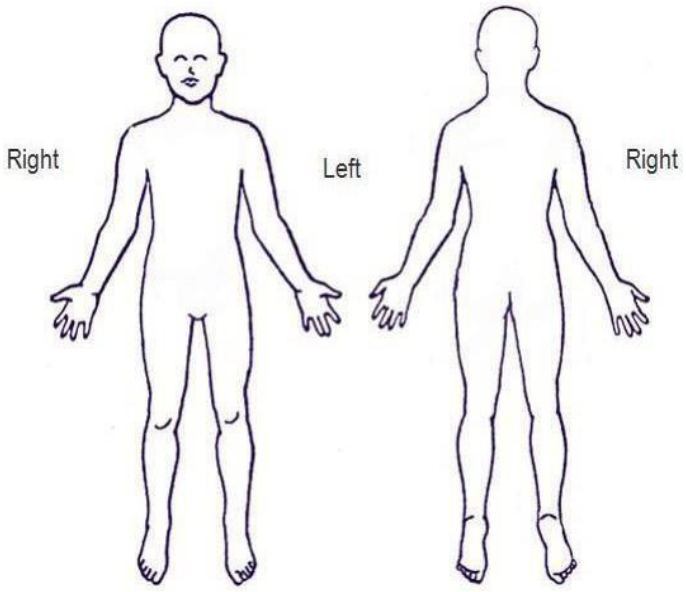
Have you had an EMG? YES NO Where:_____When:_____

Have you had Pain Injections? YES NO Where:_____When:_____
What type:_____

Are you currently working? YES: ___Full time _Part time __With restrictions Occupation: _____
NO: I have not worked since_____ _I am disabled _I am retired
__Homemaker __Unemployed ___Student ___Other: _____

Please be sure to fill this out as accurately as possible. This will become part of your permanent medical record and will be used to compare your progress throughout your treatment. Mark the area on your body where you feel the described sensations(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas.

Sharp/Stabbing Pain (xxx) Numbness (---) Pins and Needles (***)
Dull Ache (000) Burning (///) Weakness (+++)



Cervical spine:

What is the RATIO of neck pain vs arm pain? (i.e.80:20) _____

I have noticed problems with:
___Gait/Walking/Balance
___Fine Motor Coordination
___Handwriting is sloppier
___Clumsiness, dropping things more frequently
___Bowel or Bladder incontinence

Lumbar Spine:

What is the ratio of back pain vs leg pain? (i.e.80:20) _____

I have noticed problems with:
___Gait/Walking/Balance
___Bowel or Bladder incontinence

Visual Analog Scale: Please circle the pain levels that most accurately represents your pain

0 = NO PAIN 10 = UNBEARABLE PAIN

Today's Pain	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10
Least Pain	0	1	2	3	4	5	6	7	8	9	10