GRANITE ORTHOPAEDICS
*Central Arizona's First Choice for Exceptional Bone & Joint Care*

**New Patient History & Intake Form**

**Patient Information**

Patient Name:_____ Date of Birth:_____

Date of Visit (Today's Date):_____ Who referred you to our office?_____

Preferred Pharmacy Name/Location: _____

Email Address:_____

**About your problem:**

Date of injury (if applicable):_____

Describe your pain symptoms (sharp/dull, throbbing, radiating, achy, etc.)_____

_____

Location of pain/symptoms:_____

Severity of pain on a scale of 1-10:_____

Associated symptoms (numbness, swelling, locking, redness, etc.)_____

Timing (When is it worse or better?):_____

Previous treatment for this condition:_____

Course (Is it getting better/worse?):_____

Right or Left-Handed (if applicable):_____

Medications (Please list all current medications or check options which applies):

_____ I brought a copy of my medication list (please provide the list to the front desk receptionist)

_____ Not currently taking any medications

| Medication Name | Dosage | # times dosage taken per day |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies** (please list all known allergies or check options which applies):

_____ I brought a copy of my allergies list (please provide the list to the front desk receptionist

_____ No known allergies

| Allergy Type | Please describe allergic reaction severity & symptoms |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Past Medical History** (Please Check all that apply): □ None

□ Anemia, Chronic
□ Anxiety
□ Asthma
□ Atrial Fibrillation
□ Breast Cancer
□ Chronic Pain
□ COPD
□ Coronary Artery Disease
□ Depression
□ Diabetes, Insulin Dependent
□ Diabetes, Non-Insulin Dependent
□ End Stage Renal Disease
□ GERD
□ Hepatitis
□ HIV/ AIDS
□ High Cholesterol
□ Hyperparathyroidism
□ Hypertension
□ Hyperthyroidism
□ Hypothyroidism
□ Leukemia
□ Lung Cancer
□ Lymphoma
□ Multiple Myeloma
□ Obesity, Morbid
□ Obesity
□ PBPH
□ Prostate Cancer
□ Radiation Therapy
□ Seizures
□ Stroke
□ Other_____

**Past Surgical History** (Please Check all that apply): □ None

□ Appendix
□ Bladder Removed
□ Breast: Mastectomy
○Right ○Left ○Both
□ Breast Lumpectomy
○Right ○Left ○Both
□ Colectomy: Colon Cancer Resection
□ Colectomy: Diverticulitis
□ Colectomy: IBA
□ Colon: Colostomy
□ Gallbladder Removal
□ Heart: Biological Valve Replacement
□ Heart: Coronary Artery Bypass Surgery
□ Heart Transplant
□ Heart: Mechanical Valve Replacement
□ Heart PTCA
□ Hernia Repair
□ Kidney Stone Removal
□ Kidney Transplant
□ Liver: Liver Transplant
□ Liver: Shunt
□ Ovaries Removed: Ovarian cancer
□ Ovaries: Tubal Ligation
□ Pancreas: Pancreatectomy
□ Prostate Removed: Prostate cancer
□ Prostate Removed: TURP
□ Rectum APR
□ Rectum: Low Anterior Resection
□ Skin: Basal Cell Carcinoma
□ Skin: Melanoma
□ Skin: Skin Biopsy
□ Skin: Squamous cell carcinoma
□ Hysterectomy
□ Hysterectomy: Uterine Cancer
□ Hysterectomy: Cervical Cancer
□ Other_____
_____
_____

**Past Orthopedic History** (Please Check all that apply): □ None

□ Ankle Fracture
□ Ankylosing Spondylitis
□ Bursitis
□ DISH
□ Epidural Injection, Spine
□ Fracture
□ Gout
□ Hip Fracture
□ HNP, Cervical
□ HNP, Lumbar
□ Metastatic Bone Disease
□ Osteoarthritis
□ Osteopenia
□ Osteoporosis
□ Primary Bone Sarcoma
□ Psoriatic Arthritis
□ Rheumatoid Arthritis
□ Ricketts
□ RSD
□ Sciatica
□ Scoliosis
□ Spine Fracture
□ Soft Tissue Sarcoma
□ Spinal Stenosis, Cervical
□ Spinal Stenosis, Lumbar
□ Vertebral Body
□ Compression Fracture
□ Vitamin D Deficiency
□ Wrist Fracture
□ Other: _____

**Past Orthopedic Surgery** (Please Check all that apply): □ None

□ Ankle Fracture ORIF
○Right ○Left ○Both
□ Carpal Tunnel Decompression
○Right ○Left ○Both
□ Cervical Spine Surgery: ACDF
□ Cervical Spine Surgery: Disc Replacement
□ Distal Radius ORIF
○Right ○Left ○Both
□ Intermedullary Nailing Femur
○Right ○Left ○Both
□ Intermedullary Nailing Tibia
○Right ○Left ○Both
□ Joint Replacement: Hip
○Right ○Left ○Both
□ Joint Replacement: Knee
○Right ○Left ○Both
□ Joint Replacement: Shoulder
○Right ○Left ○Both
□ Knee Arthroscopy
○Right ○Left ○Both
□ Kyphoplasty/ Vertebroplasty
□ Lumbar Spine Surgery: Decompression
□ Lumbar Spine Surgery: Decompression & Fusion
□ Lumbar Spine Surgery: Disc Replacement
□ Rotator Cuff Repair
○Right ○Left ○Both
□ Other:_____
_____

**Family History**

| | Mother | Father | Sister | Brother | Daughter | Son | Other |
|---|---|---|---|---|---|---|---|
| *Hypertension* | | | | | | | |
| *Osteoarthritis* | | | | | | | |
| *Osteoporosis* | | | | | | | |
| *Scoliosis* | | | | | | | |
| *Other:* | | | | | | | |

_____ No Family History (Checking This box indicates no past family medical history)

**Social History** (Please check all that apply):

**Cigarette Smoking**
□ Never Smoked
□ Quit: former smoker
□ Smokes less than daily
□ Smokes daily
○ # of packs a day

**Alcohol Use**
□ Do not drink alcohol
□ Less than 1 drink a day
□ 1-2 drinks a day
□ 3 or more drinks a day

**Exercise Frequency**
□ Several times a day
□ Once a day
□ Few times a week
□ Few times a month
□ Never

**Review of Systems** * (Check yes or no if you are currently experiencing any of the following):

| Symptom: | Yes | No |
|---|---|---|
| **Joint Pain** | | |
| **Joint Swelling** | | |
| **Joint Stiffness** | | |
| **Unsteady Gait** | | |
| **Numbness** | | |
| **Tingling** | | |
| **Dizziness** | | |
| **Headaches** | | |
| **Tremor** | | |
| **Fatigue** | | |
| **Fever** | | |
| **Chills** | | |
| **Weight Gain** | | |
| **Poorly Healing Wounds** | | |
| **Redness** | | |
| **Rash** | | |
| **Itching** | | |
| **Scarring/ Keloids** | | |
| **Easy Bleeding** | | |
| **Easy Bruising** | | |
| **Chest Pain** | | |
| **Palpitations** | | |
| **Fainting** | | |
| **Excessive thirst or urination** | | |
| **Heat/ Cold Intolerance** | | |
| **Nausea Vomiting** | | |
| **Diarrhea** | | |
| **Nose Bleeds** | | |
| **Shortness of Breath** | | |
| **Anxiety** | | |
| **Depression** | | |

**Alerts*** (Check yes or no for the following):

| Alert: | Yes | No |
|---|---|---|
| **Blood Thinners** | | |
| **Pacemaker** | | |
| **Rheumatoid Arthritis** | | |
| **Latex Allergy** | | |
| **Pregnant** | | |
| **Under pain contract with another provider** | | |
| **Shellfish/ Iodine Allergy** | | |

*Please inform Physician, Medical Assistant, or Front Office Staff of any other medical conditions or concerns