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