SUBURBAN ORTHOPAEDICS
Improving Your Quality of Life

Demographic & History Intake

Last Name: _____ First Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (night): _____

Email Address: _____ Occupation / Workplace: _____

Emergency Contact (name): _____ Emergency Contact (number): _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Primary Care Provider: _____ ***Referring Physician:*** _____

Preferred Pharmacy

(Primary

Name: _____

Phone Number: _____

City or Zip Code: _____

Insurance Policy

Primary

Insurance Name : _____

Adress:_____

Policy Holder :_____

Policy Holder DOB:_____Relationship_____

ID Number: _____ Group Number _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Irregular Heartbeat
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Hyperlipidemia
- ☐ Ischemic Heart Disease
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis (Blood Clot)
- ☐ Depression
- ☐ Diabetes: *Insulin*
- ☐ Diabetes: *Non-Insulin*
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity: *Morbid*
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke

☐ NONE

☐ Other

_____
_____
_____
_____

History and Intake Form

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Breast: *Lumpectomy*
  SPECIFY: *Right* *Left* *Both*
- ☐ Breast: *Mastectomy*
  SPECIFY: *Right* *Left* *Both*
- ☐ Colon (Colectomy): *Colon Cancer Resection*
- ☐ Colon (Colectomy): *Diverticulitis*
- ☐ Colon (Colectomy): *Inflammatory Bowel Disease*
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Gastric Bypass
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Tonsillectomy
- ☐ Uterus: Hysterectomy
- ☐ Uterus (Hysterectomy): Cesarean Section
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer

- ☐ NONE

- ☐ Other

_____
_____
_____
_____

History and Intake Form

Orthopedic History

Have you had any of the following?

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ DISH
- ☐ Epidural Injections
- ☐ Fracture
- ☐ Gout
- ☐ Handedness –
  SPECIFY: *Right Left Both*
- ☐ Hip Fracture
- ☐ HNP -
  SPECIFY: *Cervical Lumbar*
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Rickets
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis:
  SPECIFY: *Cervical Lumbar*
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture

- ☐ NONE

- ☐ Other

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_____
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_____

Orthopedic Surgical History

Have you had any of the following?

- ☐ Achilles Tendon Repair
- ☐ ACL Reconstruction
- ☐ Ankle Fracture ORIF
  SPECIFY: *Right Left Both*
- ☐ Bunion Correction
- ☐ Carpal Tunnel Decompression
  SPECIFY: *Right Left Both*
- ☐ Cervical Spine Surgery: *ACDF*
- ☐ Cervical Spine Surgery: *Disc Replacement*
- ☐ CMC Arthroplasty
- ☐ Distal Radius ORIF
  SPECIFY: *Right Left Both*
- ☐ Ganglion Cyst Excision
- ☐ IMN *Femur*
  SPECIFY: *Right Left Both*
- ☐ IMN *Tibia*
  SPECIFY: *Right Left Both*
- ☐ Joint Replacement: *Hip*
  SPECIFY: *Right Left Both*
- ☐ Joint Replacement: *Knee*
  SPECIFY: *Right Left Both*
- ☐ Joint Replacement: *Shoulder*
  SPECIFY: *Right Left Both*
- ☐ Knee Arthroscopy
  SPECIFY: *Right Left Both*
- ☐ Kyphoplasty / Vertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine: *Decompression*
- ☐ Lumbar Spine: *Decompression and Fusion*
- ☐ Lumbar Spine: *Disc Replacement*
- ☐ Meniscus Repair
- ☐ Reverse Total Shoulder Replacement
- ☐ Revision of Total *Hip* Arthroplasty
- ☐ Revision of Total *Knee* Arthroplasty
- ☐ Revision of Total *Shoulder* Arthroplasty
- ☐ Rotator Cuff Repair
  SPECIFY: *Right Left Both*
- ☐ Shoulder Arthroscopy
- ☐ Trigger Finger Release

- ☐ NONE
- ☐ Other

_____
_____
_____

History and Intake Form

Orthopedic Family History

Is there a history of any of the following? (*Immediate family

- ☐ Charcot Marie Tooth Disease
- ☐ Diabetes
- ☐ Hypertension
- ☐ Multiple Hereditary Exostosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Scoliosis

- ☐ NONE

- ☐ Other _____

Orthopedic Pediatric History

Is there a history of any of the following?

- ☐ Breech Position
- ☐ Cerebral Palsy
- ☐ Flatfeet (Pes Plano valgus)
- ☐ Genu Valgum
- ☐ Genu Varum
- ☐ Hip Dysplasia
- ☐ Neonatal Sepsis
- ☐ Pavlik Harness as Infant
- ☐ Spina Bifida
- ☐ Spondylolisthesis

- ☐ NONE

- ☐ Other _____

History and Intake Form

Orthopedic Interventional Pain History

Have you had any of the following?

- ☐ Epidural Injection(s) – Cervical
- ☐ Epidural Injection(s) – Thoracic
- ☐ Epidural Injection(s) – Lumbar
- ☐ Facet Injection(s) – Cervical
- ☐ Facet Injection(s) – Thoracic
- ☐ Facet Injection(s) – Lumbar
- ☐ Intrathecal Pump
- ☐ Medial Branch Block – Cervical
- ☐ Medial Branch Block – Thoracic
- ☐ Medial Branch Block – Lumbar
- ☐ Rhizotomy – Cervical
- ☐ Rhizotomy – Thoracic
- ☐ Rhizotomy – Lumbar
- ☐ Spinal Cord Stimulator

- ☐ NONE

- ☐ Other _____

Medications

Please list ALL current medications *(or check the box if it applies)*

- ☐ *Currently not taking any medication(s)*

Medication	Dosage	Frequency

History and Intake Form

Allergies

Please list ALL known allergies *(or check the box if it applies)*

☐ *No Known Allergies (NKA)*

Using the following options, describe your reaction(s) with severity provided below

Reaction Types			Severity Scale
Anaphylaxis	Angioedema	Diarrhea	Mild
Dizziness	Fatigue	GI upset	Mild to Moderate
Hives	Liver toxicity	Nausea	Moderate
Rash	Shortness of breath	Swelling	Moderate to Severe
Weal	Other: (specify)		Severe
			Fatal

Allergy	Reaction(s)	Severity
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____
4.) _____	_____	_____
5.) _____	_____	_____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Exercise Frequency (please choose one):

- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

History and Intake Form

Family History

Please include only first-degree relatives:

_____ _____

_____ _____

_____ _____

Review of Systems

Alerts

Please check yes for the following if it applies:

Symptom	Yes	Symptom	Yes	Symptom	Yes
Joint Pain		Poor healing wounds		Ringing in ears	
Joint swelling		Redness		Hoarseness	
Joint stiffness		Rash		Heartburn	
Unsteady gait		Itching		Nausea/vomiting	
Numbness		Scarring/ keloids		Constipation	
Tingling		Easy bleeding		Diarrhea	
Headaches		Easy bruising		Shortness of breath	
Dizziness		Enlarged nymph nodes		Wheezing	
Tremors		Chest pain		Cough	
Fatigue		Palpitations		Hurts to breathe	
Unexpected weight loss		Fainting		Nervousness	
Fever		Heart murmur		Anxiety	
Chills		Leg cramps		Depression	
Weight gain		Nose bleeds		Hallucinations	

Alert	Yes
Pacemaker	
Blood thinners	
Defibrillator	
Premedication prior to procedures	
Rheumatoid Arthritis	
RSD	
Allergy to shellfish/iodine	
Allergy to latex	
Allergy to adhesive	
Under pain management	