Colorado Family Orthopaedics

JON A. GARRAMONE, MD

BOARD CERTIFIED ORTHOPAEDIC SURGEON DATE_____

PATIENT INFORMATION SHEET

PLEASE FILL OUT ALL INFORMATION

NAME FIRST_____ MI_____ LAST_____

ADDRESS_____

CITY _____STATE_____ ZIP CODE_____

HOME PHONE ( )_____WORK( )_____CELL( )_____

DATE OF BIRTH_____SOCIAL SECURITY NUMBER_____

E-MAIL ADDRESS_____

PRIMARY CARE PHYSICIAN_____REFERRING PHYSICIAN_____

PHARMACY_____ OCCUPATION_____

(IF THIS IS A MINOR) MOTHER'S AND FATHER'S NAMES _____

DOMINANT HAND/FOOT _____ RIGHT _____ LEFT

HOW DID YOUR INJURY HAPPEN? _____

HISTORY OF PRESENT ILLNESS

1. Is your problem a result of an injury or accident?

☐ No Injury ☐ Injury ☐ Injury at Work ☐ Auto Accident ☐ Sport Injury ☐ Prior Surgery

Onset Date:_____

2. Have you had a problem like this before? ☐ Yes ☐ No

3. Have you been seen in the ER for this problem? ☐ Yes ☐ No

4. Rate the pain (10 being the most pain).

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

5. Do the symptoms wake you from sleep? ☐Yes ☐No

6. Please describe the symptoms. Please choose one.

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐Shooting

7. What is the timing of the symptoms?

☐ Constant ☐ Intermittent (comes and goes)

8. Is the problem getting better or worse?

☐ Getting Better ☐ Getting Worse ☐ Unchanged

9. What makes the symptoms worse?

☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending ☐ Stairs ☐ Twisting ☐ Moving ☐ Lying in Bed

☐ Running ☐ Walking ☐ Athletics ☐ Standing ☐ Gripping ☐ Lifting ☐ Reaching Overhead

10. Are there any other symptoms associated to this problem:

☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping

☐ Popping ☐ Tingling ☐ Weakness ☐ Giving Way

Prior Treatment / Testing

Have you had any prior tests for this problem?

☐ None ☐ X-rays ☐ MRI ☐ CT Scan ☐ Nerve Test (EMG) ☐ Bone Scan

Have you had any prior treatments for this problem? ☐ Yes ☐ No

Past Surgical History

Select all previous hospitalizations/surgeries: ☐ None

☐ Aneurysm (Brain) Surgery
☐ Aortic Bypass/Vascular Surgery
☐ Appendectomy
☐ Cataract/Eye Surgery
☐ Cholecystectomy (Gallbladder)
☐ Heart Surgery
☐ Hernia Repair
☐ Other Surgery_____

☐ Hysterectomy
☐ LAP Band
☐ Lumpectomy
☐ Mastectomy
☐ Malignancy / Cancer
☐ Stents

Orthopaedic Surgery	Right	Left
Arthroscopy: Knee	☐	☐
Arthroscopy: Shoulder	☐	☐
Carpal Tunnel Release	☐	☐
Rotator Cuff Repair	☐	☐
Total Hip Replacement	☐	☐
Total Shoulder Replacement	☐	☐

Spinal Surgery - Indicate Level: ☐

Other Orthopaedic Surgery: _____

Medical Questions

Mark all that currently apply:

☐ Metal in body ☐ Claustrophobic ☐ Pregnant ☐ Sleep Apnea ☐ Use a C PAP ☐ Snores

Are you taking blood thinners? ☐ Yes ☐ No

Present and Past Health Conditions

Please Indicate if you have experienced any of the following symptoms; past or present?

			None	Comments
	☐ None for all			
☐ Heart Attack	☐ Cardiac Irregularities (type)	☐ High Cholesterol	☐	
☐ Hypertension	☐ Anxiety/Depression	☐ Anemia	☐	
☐ Asthma	☐ Sleep Apnea	☐ Shortness of Breath	☐	
☐ Bleeding Problems	☐ Blood Clotting Abnormalities		☐	
☐ Liver Disease	☐ Kidney Disease	☐ Gout	☐	
☐ Frequent Falls	☐ Arthritis	☐ Numbness	☐	
☐ Stroke	☐ Seizures	☐ Cancer	☐	
☐ Thyroid Disorder	☐ Diabetes		☐	
☐ Past Health Unknown				

Allergies/Medications

Please list allergies: _____ **Reaction:** _____

_____ _____

_____ _____

Please list medications and dosage: ☐ **Takes No Medications**

_____ _____

_____ _____

_____ _____

_____ _____

Family History

Have any direct relatives had any of the following disorders? ☐ None for All

Father ☐None ☐Diabetes ☐Heart Disease ☐Hypertension
☐Bleeding Problems ☐Epilepsy ☐Connective Tissue ☐Muscular Dystrophy
☐Stroke ☐Osteoporosis ☐Rheumatoid Arthritis ☐Cancer

Comments:_____

Mother ☐None ☐Diabetes ☐Heart Disease ☐Hypertension
☐Bleeding Problems ☐Epilepsy ☐Connective Tissue ☐Muscular Dystrophy
☐Stroke ☐Osteoporosis ☐Rheumatoid Arthritis ☐Cancer

Comments:_____

Sibling: ☐None ☐Diabetes ☐Heart Disease ☐Hypertension
☐Bleeding Problems ☐Epilepsy ☐Connective Tissue ☐Muscular Dystrophy
☐Stroke ☐Osteoporosis ☐Rheumatoid Arthritis ☐Cancer

Comments:_____

Social History

SMOKING:

Have you ever smoked: ☐ yes ☐ no How many years did you smoke?_____When did you quit?_____

If currently smoking, estimate the number of packs per day you smoke _____Smokeless tobacco ☐ yes ☐ no

ALCOHOL USAGE: ☐ Never ☐ Rarely ☐ Socially ☐ Daily ☐ Recovering Alcoholic

MARITAL HISTORY: ☐Married ☐Single ☐ Divorced ☐ Widowed

EMPLOYMENT: ☐Working ☐Student ☐ Retired ☐ Disabled ☐Occupation_____

HEIGHT:_____ WEIGHT:_____