ORTHOPEDIC CLINIC REVIEW

1633 Medical Center Point, Colorado Springs, CO 80907

Patient Name_________________________________ Today's Date ___________________________

Please check any symptoms or conditions that apply to you:

Constitutional/General ☐ Chills ☐ Fatigue (feeling tired)	Neurological (Brain / Nerves) ☐ Difficulty Walking	Reason for Today's Visit ______________________________ ______________________________ ______________________________ How long? ______________________________
Muscles and Joints ☐ Painful Joints ☐ Swollen Joints ☐ Stiff Joints	Respiratory ☐ Shortness of Breath Cardiovascular ☐ Chest Pain	Other Symptoms ______________________________ ______________________________

HEALTH AND SURGICAL HISTORY

Have you ever had general anesthesia? ☐ **No** ☐ **Yes**

Do you have any problems with anesthesia? ☐ **No** ☐ **Yes**

Do you have any blood relatives who had problems with anesthesia? ☐ **No** ☐ **Yes**

Have you ever been diagnosed with osteoporosis? ☐ **No** ☐ **Yes**

Have you ever been diagnosed with osteopenia? ☐ **No** ☐ **Yes**

Have you ever broken/fractured a bone? ☐ **No** ☐ **Yes**

If yes, which bone and when?____

Are you right or left handed? ☐ **Right** ☐ **Left**

Are you currently employed? ☐ **No** ☐ **Yes** **Occupation**___________________________

Are you a CURRENT tobacco smoker? ☐ **No** ☐ **Yes**

Did you ever smoke tobacco? ☐ **No** ☐ **Yes** ______ **packs/day for** _____ **years.**

Do you drink alcohol? ☐ **No** ☐ **1-2 times/wk** ☐ **1-2 times/month** ☐ **Daily**

Do you use recreational drugs? ☐ **No** ☐ **Yes** **Which ones?** ______________________________

Do you exercise? ☐ **No** ☐ **1-2 times/wk** ☐ **1-2 times/month** ☐ **Daily**

What kind of exercise do you do? ____

____

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What **prescription medications** do you take**?** (Please include pills, inhalers, creams, patches, etc.)

Name:	**Dose:**	**For What Condition:**
____________________	_____________	____
____________________	_____________	____
____________________	_____________	____
____________________	_____________	____

Do you take any **over-the-counter products** regularly? (Please include herbal supplements, vitamins, etc.)

____

____

____

Allergies: ____

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DaVita Medical Group - Medical Center Point

Exit 146
Garden of the Gods Rd.
Austin Bluffs Pkwy.
25
Nevada
N
W
E
S
Medical Ctr. Pt.
Union Blvd.
Gap Rd.
Exit 145
Fillmore
Templeton
Circle Dr.
Constitution

*map not to scale

1633 Medical Center Point

Located on the northwest corner of Fillmore & Union

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