OPTUM®

1633 Medical Center Point
Colorado Springs, CO 80907

Orthopedic new patient form

Patient's name: _____ Date of birth: _____/ _____/ _____

Please check any symptoms or conditions that apply to you:

Today's date: _____/ _____/ _____

Constitutional/general ☐ Chills ☐ Fatigue (feeling tired)	**Neurological (brain/nerves)** ☐ Difficulty walking	**Reason for today's visit** _____ _____ _____
Muscles and joints ☐ Painful joints ☐ Swollen joints ☐ Stiff joints	**Respiratory** ☐ Shortness of breath	**How long?** _____
	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 have 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/week** ☐ **1–2 times/month** ☐ **Daily**

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

Do you exercise? ☐ **No** ☐ **1–2 times/week** ☐ **1–2 times/month** ☐ **Daily**

What kind of exercise do you do? _____

_____

(continued on back)

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

Name of medication:	**Dose:**	**For what condition:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

_____

_____

_____

Allergies: _____

Patient's signature: _____ Date: _____/ _____/ _____

Reviewed by: _____ Date: _____/ _____/ _____

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