Archway Orthopedics and Hand Surgery
Dr. Shawn Kutnik
Patient Demographics

Today's Date: _____ ***Email:*** _____

Name: _____ ***DOB:*** _____ ***Age:*** _____

Address: _____

City: _____ ***State:*** _____ ***Zip:*** _____

Primary phone #: _____

__Married __Single __Widowed __Divorced

Race: _____ ***Ethnicity:*** __Hispanic __Non-Hispanic __Decline

Preferred language if other than English: _____

__Smoker __Former Smoker __Nonsmoker

Emergency contact or Parent information if patient is minor:

Name: _____ ***Relationship:*** _____

Phone: _____

Employer: _____

Employer phone: _____

Insurance: ***(please provide the ins comp. name even though a copy of the card is scanned to your chart)***

Primary: _____

Insurance holder info:

Name/DOB: _____

Secondary: _____

Insurance holder info:

Name/DOB: _____

Primary Doctor Name/Phone:

_____

_____

Preferred Pharmacy (address/phone):

_____

_____

Referring Doctor Name/Phone:

_____

___same as above

_____

ARCHWAY
ORTHOPEDICS AND HAND SURGERY
Patient History

Name: _____ ***Date:*** _____

Height: _____***ft*** _____***in*** ***Weight:*** _____***lbs*** ***Age:*** _____

PRESENTING SYMPTOMS:

Reason you are being seen: _____

Did you have an injury? __YES __NO ***Date of injury:*** _____

If no injury, when did your symptoms begin? _____

Describe your symptoms: (check all that apply)

Severity of pain: __No pain __Mild pain __Moderate pain __Severe pain

Quality of pain: __Sharp __Burning __Dull __Aching

Is the pain: __Continuous __Activity related __Night pain __Unpredictable

What makes your symptoms better? _____

What makes your symptoms worse? _____

What treatments have you tried? (check all that apply)

__Physical/Occupational Therapy __Activity modification/Rest __Steroid Injections __Cast/splint

__Home exercises __Anti-inflammatories __Other: _____

Have you had any x-rays, MRI or other testing? __NO __YES ***If yes, where:*** _____

PAST MEDICAL HISTORY: (check all that apply)

__Diabetes (Type 1 or Type 2) __High Blood Pressure __High Cholesterol __Stroke __Gout

__Blood Clots __Heart Disease __A-Fib __Thyroid Disorder

__Emphysema/COPD __Neuropathy __HIV/AIDS __Cirrhosis of the liver

__Depression __Rheumatoid Arthritis __Osteoarthritis __ADHD

__Cancer – type: _____ __Other: _____

PREVIOUS SURGERY:

Procedure:	***Year:***

FAMILY HEALTH HISTORY:

__adopted, unknown family history	*__noncontributory*
Brother(s)	__Alcoholism __Arthritis __Blood Clots __Diabetes __Heart disease __High Blood Pressure __Gout __Mental Illness __Stroke __Thyroid Disease __Cancer
Father	__Alcoholism __Arthritis __Blood Clots __Diabetes __Heart disease __High Blood Pressure __Gout __Mental Illness __Stroke __Thyroid Disease __Cancer
Mother	__Alcoholism __Arthritis __Blood Clots __Diabetes __Heart disease __High Blood Pressure __Gout __Mental Illness __Stroke __Thyroid Disease __Cancer
Sister(s)	__Alcoholism __Arthritis __Blood Clots __Diabetes __Heart disease __High Blood Pressure __Gout __Mental Illness __Stroke __Thyroid Disease __Cancer

SOCIAL HISTORY:

Are you: (check one) __Married __Divorced __Single __Widowed

Do you smoke or use any tobacco products: (check one) __YES __NO __Former (year quit: _____)

If yes – number of cigs/packs per day: _____ ***What year did you start:*** _____

Other form of tobacco used: _____

Alcohol Use: (check one) __Never __Rare __Social __Frequently __Recovering Alcoholic

Illegal Drug Use: (check one) __Never __In the past __Currently - type of drug(s): _____

ALLERGIES: __None

Medication name:	***Reaction:***	***Allergy to latex? __Y __N***

CURRENT MEDICATIONS: __currently not taking any prescription or over-the-counter meds

Medication name (including over-the-counter):	***Dosage:***	***Directions:***

REVIEW OF SYSTEMS: ***(check symptoms you have had in the past 30 days)***

Constitutional:	__Fevers __Chills __Weight loss/gain
Neck/HEEN(m)T:	__Swollen glands __Headaches __Dizziness __Vision changes __Hearing loss/difficulty __Ringing in ears __Nose bleeds __Dental cavities __Bleeding gums __Difficulty with swallowing
Cardiovascular:	__Chest pain __Shortness of breath with activity
Respiratory:	__Wheezing __Shortness of breath
Gastrointestinal:	__Nausea __Vomiting __Diarrhea __Constipation
Genitourinary:	__Urinary difficulty
Integumentary (Skin or Breast):	__Rashes __Cysts
Neurologic:	__Seizures __Memory loss
Psychiatric:	__Anxiety __Sleep disturbance
Allergies:	__Seasonal allergies

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

_____
Patient name (Please Print)

_____
Patient/Parent Signature

_____
Date

Office use –
BP: _____
__meds
__allergies
__ht/wt
__pt portal offered

Reviewed by:_____