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: _______________________________ Secondary: ___________________________________

Insurance holder info: Insurance holder info:

Name/DOB: ____________________________ 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:______