PIKES PEAK ORTHOPAEDICS

Name_____ Date of Birth _____

Address _____

Email address _____

Primary Phone _____ **May we text message** Yes / No

Alternate Phone _____ May we text message Yes / No

PRIMARY INSURANCE:

Insurance Carrier _____ ID # _____

SECONDARY INSURANCE:

Insurance Carrier _____ ID # _____

Social Security Number _____

Emergency Contact _____ Relationship _____
Name Phone #

Primary Care Physician _____ **Referred by**_____

Have you been seen by Dr. Rahill before? Y / N *If yes - when and for what?_____

_____

Are you here for a **second opinion**? For what specifically? _____

_____

Patient Name _____ Date _____

REASON FOR VISIT - Concerns/Symptoms (onset, diagnosis, symptoms, duration etc.) **please be specific**.

** If you have imaging you **MUST** bring that to your appointment.

_____

_____

_____

APPROXIMATE HEIGHT : _____ APPROXIMATE WEIGHT : _____

CURRENT **MEDICATIONS** - (dose and duration taking)

_____

_____

_____

ALLERGIES TO MEDICATION OR OTHER - (list what you are allergic to and the symptoms)

_____

_____

_____

PAST SURGERIES (list **ALL** - type of surgery and approximate date)

_____

_____

_____

Patient Name _____ Date _____

PAST MEDICAL HISTORY - Have you ever had **(check all that apply)**

- o Angina
- o Allergies
- o Anemia
- o Asthma
- o Bronchial Infection
- o Bronchitis
- o Cancer _____
- o Colitis
- o Crohn's Disease
- o COPD
- o Cystic Fibrosis
- o Depression
- o Diabetes
- o Emphysema
- o Epilepsy
- o Goiter
- o Heart Murmur
- o High Blood Pressure
- o High Cholesterol
- o Hypothyroidism
- o Hepatitis
- o HIV/AIDS
- o Hypertension
- o Kidney Stones/Disease
- o Pneumonia
- o Pulmonary embolism
- o Stomach or peptic ulcer
- o Rheumatic fever
- o Tuberculosis
- o Snoring
- o Stress
- o Wheezing
- o Other Medical Conditions: _____

_____

FAMILY MEDICAL HISTORY

	Family Member
o Blood Clots	_____
o Cancer _____	_____
o Diabetes	_____
o Heart Disease	_____
o Kidney Disease	_____
o Liver Disease	_____
o Stroke/Heart Attack(s)	_____
o Thyroid Disease	_____
o Other _____	_____

SMOKING HISTORY

Do you smoke now? YES or NO

Have you ever smoked? YES or NO

If yes, how much and for how long? _____

SUBSTANCE USE

Category	Frequency (how much and how often)	Do you currently use this?
Alcohol	_____	YES or NO
Marijuana/Cannabis	_____	YES or NO
Opioids	_____	YES or NO
Other	_____	YES or NO

Patient Name ____ Date ______________________________

HAVE YOU HAD **ANY IMAGING** - X-Ray, CT Scan or MRI **(when and where?)**
** If you have imaging you **MUST** bring that to your appointment.

____

____

____

I attest that this **intake form is complete** with my **medical history and filled out to the best of my knowledge**.

I realize that **if I show up to an appointment, and do not bring my imaging, my appointment will be canceled and have to be rescheduled**

X____ Date ___________________________
Signature

- -

Office use only:

BP: _______________ *Temp:* _______________ *Ht:* _______________ *Wt:* _______________

____

____

____

CPT code: _______________________________________ Dx code: _______________________________________