Colorado Center
for Arthritis & Osteoporosis, LLC

Welcome to Colorado Center for Arthritis & Osteoporosis, LLC. Our commitment to you and to your referring physician is to provide the highest quality, most efficient and caring service possible. Please read and follow the check list below.

We look forward to meeting you.

First Visit Checklist:

___1. Bring your completed Patient Health Questionnaire*.
___2. Bring your insurance card(s).
___3. Bring a photo ID.
___4. Bring your medical records (if applicable).
___5. Be prepared to pay your insurance co-pay.
___6. Arrive 10-15 minutes before your scheduled appt. time**.

*Please remember: you must have your COMPLETED Health Questionnaire with you in order to be seen.

**Please complete packet using blue or black ink ONLY.

*****Due to changes related to the Affordable Care Act, we need to collect co-pays and co-insurance at check-in, otherwise we will have to reschedule your appointment.**

*****Due to the length and complexity of a new consultation, patients arriving late may need to be rescheduled.**

LONGMONT
1715 Iron Horse Drive
Suite 100
Longmont, CO 80501

BOULDER
1840 Folsom Street
Suite 105
Boulder, CO 80302

BROOMFIELD/
SUPERIOR
1910 Coalton Road
Broomfield, CO 80021

WHEAT RIDGE
3455 Lutheran Parkway
Bldg. 8, Suite 100
Wheat Ridge, CO 80033

NORTHGLENN
11990 Grant Street
Suite 108
Northglenn, CO 80233

DENVER
425 S Cherry Street
Suite 300
Denver, CO 80246

PHONE 720.494.4700 TOLL FREE 1.877.508.5510 FAX 720.494.4706 WEBSITE www.ccao.net

Revised 9/11/2019

Colorado Center for Arthritis & Osteoporosis
New Patient Information Form

Date of first appointment: _____

Name: _____ Date of birth: _____ Sex:_____
LAST FIRST M.I.

Address: _____ Email: _____
STREET Apt. #

_____ ____ Opt-in to patient portal
CITY STATE ZIP

Phone(s): Home: _____ Cell: _____ Work: _____

Primary Language (circle one): English Spanish Other: _____

Race/Ethnicity (circle one): Caucasian Hispanic Asian African American Native American Chinese Filipino Japanese Native Hawaiian Pacific Islander Multi-Racial Decline to give/unknown Other:_____

Referred by (circle one): Self Family Friend Physician Other health professional

Name of person making referral: _____

Name of primary care provider (general or family doctor): _____

Do you have an orthopedic surgeon? _____ If so, name: _____

A referral letter will be sent to your **primary care provider** and to the **physician who referred you** (if any). Please list any other people that you would like to receive a letter below:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Current symptoms

Briefly describe the symptoms that prompted this visit: _____

_____

_____

_____

_____

Approximate date when symptoms began: _____ Are the symptoms getting **better**, **worse** or **staying the same** (circle one)?

What diagnoses have you been given? _____

What treatments (other than medications, which will be listed later) have you received? _____

_____

Please list other practitioners that you have seen for this problem: _____

_____

Name: _____ Date of birth: _____
LAST FIRST M.I.

Systems Review (check if you have these symptoms)

General:

_____ Recent weight gain
(Intentional? Y / N Amount:)
Over what period? _____
_____ Recent weight loss
(Intentional? Y / N Amount:)
Over what period? _____
_____ Fatigue
_____ Fever
_____ Night sweats

Eyes:

_____ Pain (**L** **R**)
_____ Redness (**L** **R**)
_____ Loss of vision (**L** **R**)
_____ Double vision
_____ Blurred vision
_____ Dryness
_____ Itching eyes

Ears, Nose and Throat:

_____ Loss of hearing (**L** **R**)
_____ Frequent nosebleeds
_____ Sores in mouth
_____ Dry mouth
_____ Difficulty swallowing

Lungs:

_____ Shortness of breath
_____ Cough
_____ Coughing up blood
_____ Wheezing
_____ Loud snoring

Heart:

_____ Chest pains
_____ Irregular heart beat
_____ Fluid retention in legs or feet
_____ Heart murmurs
_____ Fingers or toes turn blue/white in the cold

Stomach and intestines:

_____ Nausea
_____ Vomiting
_____ Vomiting of blood or coffee ground material
_____ Heartburn
_____ Stomach pains
_____ Diarrhea
_____ Constipation
_____ Blood in stools
_____ Black stools

Urinary and reproductive:

_____ Pain or burning on urination
_____ Frequent urination
_____ Urination during the night (# of times _____)
_____ Blood in Urine
_____ Genital rashes
_____ Genital ulcers

Men only:

_____ Discharge from penis
_____ Difficulty with erections

Women only:

_____ Vaginal dryness
Number of pregnancies _____
Number of miscarriages _____
Age at which periods stopped (menopause): _____
Was menopause **natural** or **surgical** (hysterectomy)? (circle one)
Have your ovaries been removed?
Yes **No** **One removed**

Blood/Lymph:

_____ Anemia
_____ Low white blood cells
_____ Low platelets
_____ Bleeding tendency
_____ Blood clots

Nervous System:

_____ Headaches
_____ Dizziness
_____ Fainting/Loss of consciousness
_____ Seizures
_____ Numbness or tingling of hands
_____ Numbness or tingling of feet
_____ Memory loss
_____ Difficulty concentrating
_____ Difficulty with balance/falling
_____ Difficulty falling asleep
_____ Difficulty staying asleep

Psychiatric:

_____ Depression
_____ Anxiety

Skin:

_____ Rash
_____ Hives
_____ Sun sensitivity
_____ Sores or ulcers
_____ Hair loss

Endocrine:

_____ Intolerant of cold
_____ Intolerant of heat

Allergic/Immunologic:

_____ Hay fever
_____ Recent infection
_____ Frequent infections

Muscles/Bones /Joints:

_____ Muscle weakness
_____ Muscle pain
_____ Neck Pain
_____ Back Pain
_____ Morning stiffness
Lasting how long?
_____ Minutes / Hours
_____ Joint pain
_____ Joint swelling
_____ Joint redness
Joints affected in the last 6 months:
_____
_____
_____

Name: _____ Date of birth: _____
LAST FIRST M.I.

Personal Medical History (check if you have ever had these conditions)

Arthritic conditions:

_____Osteoarthritis _____Rheumatoid arthritis _____Fibromyalgia
_____Lupus _____Ankylosing spondylitis _____Osteoporosis
_____Gout _____Arthritis (unknown type) _____Childhood arthritis _____Osteopenia

Other conditions:

_____Epilepsy/seizures _____Heart problems _____Kidney disease _____Tuberculosis
_____Migraine headaches _____High blood pressure _____Asthma _____Diabetes
_____Emphysema/COPD _____High cholesterol _____Cataracts _____Rheumatic fever
_____Depression _____Stroke _____Glaucoma _____Underactive thyroid (hypothyroidism)
_____Bipolar disorder _____Psoriasis _____Stomach ulcers
_____Cancer _____Celiac Disease _____Hyperparathyroidism _____Overactive thyroid (hyperthryoidism)
Type of cancer:_____ _____HIV infection _____Hepatitis B infection _____Hepatitis C infection

Other significant illness: _____
_____

Surgical History

Type of operation Year Reason

_____
_____
_____
_____
_____

Any serious injuries/accidents? **Y** **N** Describe: _____

Health Maintenance

Date of last physical: _____ Date of last bone density scan (DXA): _____

Date of last eye examination: _____ Date of last TB skin test: _____Result: **+** **–**

Bone Health

Have you ever broken a bone? **Y** **N** If so, when, how and which bone: _____

How tall were you at your tallest? _____ Have you lost height? **Y** **N** If so, how much? _____

Have you ever taken prednisone or similar steroid for more than a few weeks at a time? **Y** **N** If so, give details as to when, how much, for what reason and how long? _____

Does anyone in your family have osteoporosis? **Y** **N** If so, who? _____

Did anyone in your family break a hip? **Y** **N** If so, who? _____

Name: _____ Date of birth: _____
LAST FIRST M.I.

Medications

Present medications (include vitamins, supplements and over-the-counter medications)

Name of medication	Strength	Times per day	Date started	How much did it help?		
				A lot	Some	Not at all

Calcium intake (please make your best guess at average amounts)

Number of glasses of milk per day: _____ Number of cups of yogurt per day: _____

Number of servings of cheese per day (1 serving = 1 slice = 1 oz.): _____

Calcium supplements: Type: _____ Milligrams per tablet: _____ Number per day: _____

Medication Allergies

Name of medication	Type of Reaction	Date

Name: _____ Date of birth: _____
LAST FIRST M.I.

Habits

Have you ever smoked? _____ If so: What year did you start? _____ How many packs per day? _____

If you have quit smoking, when did you quit? _____

Do you drink alcohol? _____If so, how many drinks per day? _____ Per week? _____

Do you use marijuana? **Y / N** If so, how do you use it? **Ingest / Topical / Smoke** Is your use **Medical** or **Recreational** (circle one)

Do you use any "street drugs" or any prescription drugs for non-medical reasons? _____

If so, which drugs? _____ Have you ever used IV drugs? _____

Do you exercise regularly? _____ If so, describe your exercise routine: _____

_____

Social History

Where were you born: _____ Where did you grow up: _____

Current Marital status (circle one): **Never married** **Married** **Widowed** **Divorced** **Separated** **Domestic partnership**

Spouse/significant other name: _____ Major illnesses of spouse: _____

Who else lives in your household: _____

Educational level: **Did not finish H.S.** **H.S. Graduate** **Some college**
Bachelor's degree **Master's degree** **Doctoral degree (list type)** _____

Occupation: _____ Presently employed? _____ Number hours per week: _____

Does your medical condition interfere with your ability to do your job? _____

Do you receive disability income? _____ Are you applying for disability? _____

Family History

	If living		**If deceased**	
	Age	Current Health	Age at death	Cause
Father				
Mother				

Number of brothers _____ Number living _____ Number of sisters _____ Number living _____

Serious illnesses in siblings _____

Number of children _____ Number living _____ Ages: _____

Serious illnesses in children _____

Do you know of any blood relative who has had (**give relationship**): Cancer (list type) _____

Rheumatoid arthritis _____
Ankylosing spondylitis _____
Osteoarthritis _____
Gout _____
Childhood arthritis _____
Arthritis (unknown type) _____

Fibromyalgia _____
Lupus _____
Osteoporosis _____
Heart problems _____
High blood pressure _____
Depression _____

Stroke _____
Asthma _____
Bleeding tendency _____
Alcoholism _____
Psoriasis _____
Diabetes _____