Peter Matsuura, M.D. Orthopaedics
History & Intake Form

Patient Name: ______________________________

Past Medical History (please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Seizures
- ☐ Stroke
- ☐ Other__________________
- ☐ **None**

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy
  ○ Right ○ Left ○ Both
- ☐ Breast: Lumpectomy
  ○ Right ○ Left ○ Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ Other__________________
- ☐ **None**

Past Orthopedic History (please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ Other__________________
- ☐ **None**
- ☐ HNP, Lumbar

Patient: ____________________________

Past Orthopedic Surgery (please check all that apply):

- ☐ Ankle Fracture ORIF
  - ○Right ○Left ○Both
- ☐ Carpal Tunnel Decompression
  - ○Right ○Left ○Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF
  - ○Right ○Left ○Both
- ☐ Intermedullary Nailing Femur
  - ○Right ○Left ○Both
- ☐ Intermedullary Nailing Tibia
  - ○Right ○Left ○Both
- ☐ Joint Replacement: Hip
  - ○Right ○Left ○Both
- ☐ Joint Replacement: Knee
  - ○Right ○Left ○Both
- ☐ Joint Replacement: Shoulder
  - ○Right ○Left ○Both
- ☐ Knee Arthroscopy
  - ○Right ○Left ○Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Rotator Cuff Repair
  - ○Right ○Left ○Both
- ☐ Other_______________________________________
- ☐ **None**

Medications (please list all current medications or check option which applies):

- ☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
- ☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option which applies):

- ☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
- ☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Social History (please check all that apply):

Cigarette Smoking

- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - o # packs per day_____

Alcohol Use

- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency

- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other______________

Family History (please inform us of your family members' medical history by marking the appropriate box)**:**

	Mother	Father	Sister	Brother	Daughter	Son	Other___________
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes							

- ☐ **No Family History** (checking this box indicates no past family medical history)

Patient: ___________________________
Preferred Pharmacy Name: _______________________________ Address: ____

Alerts* (check yes or no for the following):

Alert	Yes	No
Blood Thinners		
Pacemaker		
Rheumatoid Arthritis		
Taking Pain Medication		
Pregnant or planning a pregnancy		

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No	System
Joint Pain			Musculoskeletal
Joint Swelling			Musculoskeletal
Joint Stiffness			Musculoskeletal
Unsteady Gait			Musculoskeletal
Numbness			Neurologic
Tingling			Neurologic
Dizziness			Neurologic
Headaches			Neurologic
Fatigue			Constitution
Unexpected Weight Loss			Constitution
Fever			Constitution
Rash			Integumentary
Itching			Integumentary
Scarring/keloids			Integumentary
Easy bleeding			Hematologic/Lymphatic
Easy bruising			Hematologic/Lymphatic
Enlarged Lymph Nodes			Hematologic/Lymphatic
Chest Pain			Cardio Vascular
Fainting			Cardio Vascular
Palpitations			Cardio Vascular
Excessive Thirst or urination			Endocrine
Nose Bleeds			ENT & Mouth
Ringing in Ears			ENT & Mouth
Hoarseness			ENT & Mouth
Corrective Lenses			Eyes
Blurred Vision			Eyes
Heartburn			Gastrointestinal (GI)
Constipation			Gastrointestinal (GI)
Bloody Stools			Gastrointestinal (GI)
Difficulty Urination			Urologic
Incontinence			Urologic
Blood in Urine			Urologic
Shortness of Breath			Respiratory
Wheezing			Respiratory
Cough			Respiratory
Nervousness			Psychiatric
Anxiety			Psychiatric
Depression			Psychiatric