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Utah Orthopaedics

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Patient Information

Please Complete Entirely **Today's Date: __/__/____**

Legal Name: ____ Nickname: ________________________

(First) (Middle) (Last) S.S. #: ____________________ Age: ____

Address: ______________________________City: __________________State: _______Zip: _________

Home Ph: ___________________ Wk Ph: __________________Cell Ph: ____________________

Email Address: ____________________Date of Birth: ___/___/_____ Preferred Pharmacy: ________________

Marital Status: S M W D Sex: M F Height: ______ Weight: _____ Rt. Handed: ___ Lt Handed: ___

Your Occupation: ________________________Employer: ______________________________________

Who referred you to this office?___________________Primary Care Physician: ________________________

Name, Phone Number, and Relationship of Emergency Contact: ____________________________________

____

System Review

Constitution: General State of Health (Very Good, Good, Fair, Poor), Recent Weight Loss, Fevers, Fatigue: ______

____

Eyes/Ears: Blindness, Pain, Glaucoma, Wear Glasses/ Contact Lenses, False Teeth (upper/lower, partial): _______

____

Nose/Mouth: Deafness, Hearing Aid(s), Nosebleeds, Broken Noses, Sinus Infections: ______________________

____

Lungs: Pneumonia, TB, Chronic Cough, Asthma, Shortness of Breath: _____________________________

Heart: Chest Pain, Irregular Heartbeat, Rheumatic Fever, Heart Attack, High/Low Blood Pressure: _____________

____

Intestine: Stomach Pain, Jaundice, Vomiting, Blood in Stool, Ulcers, Hernias: __________________________

G.U.: Difficulty Urinating, Dribbling, Bloody Urine, Frequent Infections, Kidney Stones: __________________

Number of Pregnancies: ______ Number of Live Births: ______ Number of C-Sec.: __________

Nervous System: Headaches, Dizziness, Convulsions, Unconsciousness, Loss of Feeling in the arms/legs: ________

____

Psychiatric: Memory Loss, Confusion, Depression, Sleep Problems, Nervousness: _______________________

Extremities: Muscle or Joint Pain, Weakness, Leg or Arm Pain, Swelling Joints: _______________________

Blood: Hepatitis, HIV/AIDS, Anemia, Leukemia, Bleeding Tendencies, Bruises Easily: ____________________

Have you ever had blood clots? ______If yes, where was the clot? ______________________________

Have you or any relative hand unusual bleeding problems during or after surgery? ____________________

Have you or any relative had a very high temperature during surgery?_____________________________

Smoking (Yes/ No)? _________ Those you use? Cigarettes, Pipe, Cigar, Chewing Tabacco? _______________

How much per day? ____________________ How Long? ___________________________________

Drinking Alcoholic Beverages (Yes/No)? _________________Type of beverages? ____________________

How much per week? _________________How Long? ______________________________________

Hobbies/ Recreational Activities? ____

Family History

Please check medical problems present in your immediate family:

☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes ☐ Kidney ☐ Bleeding ☐ Ulcer/ Stomach
☐ Arthritis ☐ Cancer Type: __________ ☐ Other: ☐ Other:

Current Complaint/ Injury, please specify: ☐ Left ☐ Right

☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Foot ☐ Back ☐ Ankle ☐ Other: ________________

How did it start? ________________________________When did it start? ____________________________________

Any Previous Problems (Yes/No)? _______________ Any other areas injured (Yes/No)? ________________________

List: ____

Describe Pain Level: ☐ 0 (no pain) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐extreme pain

Frequency of Pain: ☐0 (none) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐Always

Describe Timing: ☐same always ☐worse in the mornings ☐worse at night ☐gets worse through the day.

Cause of Complaint/ Injury

Is this work related (Yes/No)?_________ Date occurred____/_____/______

How do you feel work caused this problem?____

Month _______Day___________Year_________

Where were you when you were hurt? ____

If a work injury or accident, describe how you were injured? ____

SPECIAL NOTE FOR WORK RELATED INJURIES:

If this is a work related injury, we are required, by law, to bill your industrial insurance carrier. Should you fail to tell us this is work related until after your personal insurance has been billed, there will be a $100.00 administrative charge to cover reprocessing of charges and refunding of payments that may have been made. This is a charge you will be personally responsible for. It cannot be paid by your personal or industrial company.

Is this auto accident related (Yes/No)? _______

Is this sports related (Yes/No)? ________

Have you been treated for this problem (Yes/No)? _____

Physician: ___________________________ City/ State: ________________________________

Hospital: ___________________________ City/ State: ________________________________

(Check any of the following you've had for this problem:

☐XRays ☐MRI ☐Injection ☐CT Scan ☐Therapy ☐Surgery

Patient History

Current Health Problems or Illnesses:

☐ Hypertension ☐Heart Disease ☐Cancer type:_______________ ☐Arthritis ☐Other:________________

☐ Ulcer/Reflux ☐Diabetes ☐Hypo/Hyperthyroid ☐Kidney ☐Depression

All Operations: ☐None ☐Yes (Please List)____

____

____

____

Allergies: ☐None ☐Yes (Please List):____

____

____

Current Medications/ Dose/ Frequency: ☐None ☐Yes (Please List) _________________________________

____

____

____

____

____

Patient Initials _______________