Welcome to **Mountain Orthopaedics**. Please complete this form as accurately as possible. This information is important in planning your care. We will be happy to assist you as needed.

Date: ________________ Name: ____
Age: ________________ Occupation: ____
Employer or School: __________________________________ Year in School: ___________
Primary Care Physician: ____
Who referred you to us: ____
Right or Left Handed?

Please describe why you are here to see the doctor by filling in the following blanks.

L or R ________________ ____________________ __________ ____________________
What **Body Part** is injured? Pain / swollen / weak / unstable **Date** this began? **Where** injured?Work/School/Other

HPI Describe in detail how this began. ____
____
____

Describe treatments you or your doctor have tried (medicines, ice, braces, therapy, which doctor).
____
____
____

Sports / Activities you enjoy. ____
____

PMHx List all medical problems you have had. (e.g. high blood pressure, diabetes, asthma, heart, etc.): ____
____
____

PSHx List all surgeries and year. (e.g. appendix 1956, heart bypass 1995, knee scope 1980, etc.)
____
____
____

MEDs List all medications you are taking. Include insulin and other injectables:

Medication	Dosage (mg strength)	How often you take this medicine?
		AM / PM / OTHER
		AM / PM / OTHER
		AM / PM / OTHER
		AM / PM / OTHER
		AM / PM / OTHER

OFFICE USE

____
____
____
____

Allergies List all allergies to medications and identify your reaction.

Medication	Reaction (circle)
	Rash / nausea / difficulty breathing / unconscious
	Rash / nausea / difficulty breathing / unconscious
	Rash / nausea / difficulty breathing / unconscious
	Rash / nausea / difficulty breathing / unconscious

Circle any other allergy:
Iodine **Shellfish** **IC Dye** **Latex** **Tape** **Other** ____________________

Fam Hx List any medical problems that run in your family (e.g. arthritis-mom, heart disease-grandpa, Prostate cancer-uncle):

____

____

Social Hx Marital Status ____________________

Number of Children at home _____________ out of home _____________

How much do you smoke? ___________ How much alcohol do you drink? ___________

If you are ill or recovering from surgery, is there someone to assist you at home? YES / NO

ROS Circle any Problems you have ever had.

Stomach ulcers (If yes, how was ulcer diagnosed?_____________________)

Blood Clots	Prednisone use
Unusual bleeding	Kidney problems
Cancer or tumors	Liver problems
Diabetes	Hepatitis / Jaundice
Heart problems	Asthma
High blood pressure	Other lung problems
Chest pain or angina	Stroke
Mitral Valve Prolapse	Seizures
Recent weight gain >20 lbs	Depression
Recent weight loss >20 lbs	Pacemaker
Sleep Disorders (Apnea, snoring, etc.)	

Other: ____

Height: ______ft. _____inches

Weight: ___________ lbs.

This information is true to the best of my knowledge. ____

(Patient or guardian signature)

Nurse: ____________________________ Physician: ____________________________