R PEPPER MURRAY, MD
JOHN C EDWARDS, MD
ERIC C JOHNSTON, MD
STEVEN B HUISH, MD
JOSHUA M HICKMAN, MD
MICHAEL M HESS, MD
DAVID W STEVENS, MD
JARED J TYSON, MD
CLINT J WOOTEN, MD

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: ______________________________________________________________________________

Please describe why you are here to see the doctor by filling in the following blanks. Right or left handed? (Circle One)
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, brace, 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 medication 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 |
| | rash / nausea / difficulty breathing / unconscious |

Circle any other allergies: Shellfish IV Dye Latex Tape Other: ________________________________

Family Hx List any medical problems that run in your family (i.e arthritis-mom, heart disease-grandpa, prostate cancer-uncle): ________________________________________________________________________________
________________________________________________________________________________

Social Hx Marital Status: ___________________________

If you are ill or recovering from surgery, is there someone to assist you at home? Y / N

Number of children at home: ____________ Number of children out of the home: _____________________

How much do you smoke? _________________ How much do you drink? ______________________________

ROS Circle any problems you have ever had:

Stomach Ulcers
Blood Clots
Unusual Bleeding
Cancer or Tumors
Diabetes
Heart Problems
High Blood Pressure
Chest pain or Angina
Mitral Valve Prolapse
Recent weight gain > 20 lbs.
Recent weight loss > 20 lbs.

Sleep Disorders (apnea, snoring, etc)
Prednisone Use
Kidney Problems
Liver Problems
Hepatitis / Jaundice
Asthma
Other Lung Problems
Stroke
Seizures
Depression
Pacemaker

Height: _________ ft. ______________inches

Weight: ____________________ lbs.

BMI: ___________________________

*This information is true to the best of my knowledge.* ________________________________________________
Patient or Guardian Signature

Nurse: _________________________________ Physician: _________________________________